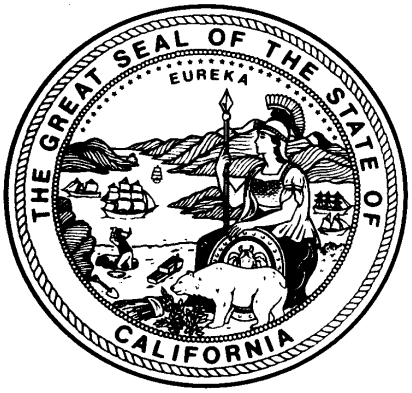
2002 Federal Annual Report
Children's Health Insurance Program



California

Gray Davis, Governor
STATE OF CALIFORNIA
January 2003

Gray Davis, Governor

The California Managed Risk Medical Insurance Board
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March 19, 2003

Cheryl Austein-Casnoff
SCHIP Director
Centers for Medicare and Medicaid Services
Mail Stop S2-01-16
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Ms. Austein-Casnoff:

Enclosed is the Annual Report of the State Children's Health Insurance Program. This report is required to be submitted to the Centers for Medicare and Medicaid Services in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Section 2108(a) of the Act provides that the State must assess the operation of the State Child Health Insurance Program (SCHIP) each fiscal year, and report to the Secretary by January 1 following the end of the fiscal year on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

The question and answer framework used in this report was updated by the National Academy of State Health Policy (NASHP) and was released to states in November 2002.

California has been successful in expanding coverage to low-income children eligible for the Healthy Families Program (California's SCHIP) and in having a positive effect in the lives of these children. Based on new estimates of eligible children, the program has enrolled nearly 8 of 10 children who are eligible for the program. By the end of the 2002 Federal Fiscal Year over 596,000 children were enrolled.

Data from a project to measure changes in the health status of children enrolled in the program show that the children in the poorest health experienced significant improvement in their health status after one year in the program. In addition, these children reported fewer sick days and improvement in their ability to pay attention in class and keep up with school activities. The data also show that they experienced fewer problems in receiving medical care.

The success of the Healthy Families Program reflects the strong collaboration among community based organizations, enrollment entities, participating health, dental and vision plans, other program partners and stakeholders. The program has enjoyed four years of wide spread public support. We look forward to its continued support and success.

If you have any questions or comments, please call me or Lorraine U. Brown, Deputy Director, at (916) 324-4695.

Respectfully,

Lesley Cummings
Executive Director

Enclosure

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble
Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist States in complying with the statute, NASHP, with funding from the David and Lucile Packard Foundation, has coordinated an effort with States to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by CMS quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR THE ANNUAL REPORT OF THE STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: **California**
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

(Signature of Agency Head)

SCHIP Program Name(s): Healthy Families / Medi-Cal for Children

SCHIP Program Type:

_____ SCHIP Medicaid Expansion Only
_____ Separate Child Health Program Only
X Combination of the above

Reporting Period: ***Federal Fiscal Year 2002*** *Note: Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02.*

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Email: **slemke@mrmib.ca.gov**

Submission Date: _____

(Due to your CMS Regional Contact and Central Office Project Officer by January 1st of each year)
Please copy Cynthia Pernice at NASHP (cpernice@nashp.org)

SECTION I: SNAPSHOT OF SCHIP PROGRAM AND CHANGES

1) To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in place and would like to comment why, please explain in narrative below this table.

	SCHIP Medicaid Expansion Program					Separate Child Health Program				
Eligibility ***Note: Report template altered to reflect California's eligibility rules.***	From	NA	% of FPL for **infants**	NA	% of FPL	From	200%	% of FPL for **infants**	250 %	% of FPL
	From	NA	% of FPL for children ages **1 through 5**	NA	% of FPL	From	134%	% of FPL for children ages **1 through 6**	250 %	% of FPL
	From	0%	% of FPL for children ages **14 through 18**	100%	% of FPL	From	100%	% of FPL for children ages **7 through 18**	250 %	% of FPL

Is presumptive eligibility provided for children?		No	X	No
	X	Yes		Yes
Is retroactive eligibility available?		No	X	No
	X	Yes, for children and adults for 3 months		Yes
Does your State Plan contain authority to implement a waiting list?	Not applicable		X	No
Does your program have a mail-in application?		No		No
	X	Yes	X	Yes
Does your program have an application on your website that can be printed, completed and mailed in?		No		No
	X	Yes	X	Yes
Can an applicant apply for your program over phone?	X	No	X	No
		Yes		Yes
Can an applicant apply for your program on-line?		No		No
	X	Yes – please check all that apply	X	Yes – please check all that apply
	X	Signature page must be printed and mailed in	X	Signature page must be printed and mailed in
	X	Family documentation must be mailed (i.e., income documentation)	X	Family documentation must be mailed (i.e., income documentation)
	X	Electronic signature is required	X	Electronic signature is required
				No Signature is required
Does your program require a face-to-face interview during initial application	X	No	X	No
		Yes		Yes

Does your program require a child to be uninsured for a minimum amount of time prior to enrollment (waiting period)?	X — No Yes specify number of months	No X — Yes, if Employer Sponsored Insurance. Note: Exceptions to waiting period should be listed in Section III, subsection Substitution, question 6 specify number of months: 3 months
Does your program provides period of continuous coverage <u>regardless of income changes?</u>	No X — Yes specify number of months: 12 Explain circumstances when a child would lose eligibility during the time period in the box below Death of the child, leave the State, applicant's request	No X — Yes specify number of months: 12 Explain circumstances when a child would lose eligibility during the time period in the box below Reach age 19, non-payment of premiums, death of the child, leave the State, applicant's request
Does your program require premiums or an enrollment fee?	X — No Yes Enrollment Fee: $ Premium Amount: $ $ Yearly cap Briefly explain fee structure in the box below	No X — Yes Enrollment Fee: $ 0 Premium Amount: $ 4–9/mo $ 0 Yearly cap Briefly explain fee structure in the box below $4 to $9 per month per child with a maximum of $27/month for a family. Applicant may pay three months and receive the fourth free. If the applicant uses Electronic Funds Transfer, he/she receives a 25% discount.
Does your program impose copayments or coinsurance?	X — No Yes	No X — Yes
Does your program require an assets test?	X — No Yes If Yes, please describe below	X — No Yes If Yes, please describe below
Is a preprinted renewal form sent prior to eligibility expiring?	X — No Yes, we send out form to family with their information precompleted and ☐ ask for confirmation ☐ do not require a response unless income or other circumstances have changed	No Yes, we send out form to family with their information precompleted and X — ask for confirmation (and verification of income) ☐ do not require a response unless income or other circumstances have changed

2. Are the income disregards the same for your Medicaid and SCHIP Programs? ☒ Yes ☐ No

3. Is a joint application used for your Medicaid, Medicaid Expansion and SCHIP Programs? ☒ Yes ☐ No

4. Have you made changes to any of the following policy or program areas during the reporting period? Please indicate "yes" or "no change" by marking appropriate column.

	Medicaid Expansion SCHIP Program		Separate Child Health Program	
	Yes	No Change	Yes	No Change
a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)		X		X
b) Application		X		X
c) Benefit structure		X		X
d) Cost sharing structure or collection process		X		X
e) Crowd out policies		X		X
f) Delivery system		X		X
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)		X	X	
h) Eligibility levels / target population		X		X
i) Eligibility redetermination process		X	X	
j) Enrollment process for health plan selection		X		X
k) Family coverage		X		X
l) Outreach	X		X	
m) Premium assistance		X		X
n) Waiver populations (funded under title XXI)		X		X
Parents		X		X
Pregnant women		X		X
Childless adults		X		X
o) Other – please specify				
a. _____				
b. _____				
c. _____				

5. For each topic you responded yes to above, please explain the change and why the change was made, below.

a) Applicant and enrollee protections (e.g., changed from the Medicaid Fair Hearing Process to State Law)	
b) Application	
c) Benefit structure	
d) Cost sharing structure or collection process	
e) Crowd out policies	
f) Delivery system	
g) Eligibility determination process (including implementing a waiting lists or open enrollment periods)	The Healthy Families Program (HFP) implemented the same financial responsibility and household rules used by Medi-Cal for Children Programs. Children screened to no-cost Medi-Cal are granted accelerated enrollment in Medi-Cal pending final eligibility determination.
h) Eligibility levels / target population	
i) Eligibility redetermination process	The HFP implemented a two-month HFP to Medi-Cal Bridging program for children determined to be below the HFP income guidelines at Annual Eligibility Review (AER). For those children, an application is forwarded to the county welfare department and, pending their Medi-Cal determination, they are granted two additional months of HFP coverage.
j) Enrollment process for health plan selection	
k) Family coverage	
l) Outreach	Due to State fiscal constraints, much of the outreach budget was eliminated. The outreach program currently consists only of payments to Certified Application Assistants (CAA) for assisting families with their application.
m) Premium assistance	
n) Waiver populations (funded under title XXI)	
Parents	
Pregnant women	
Childless adults	
o) Other – please specify	
a.	
b.	
c.	

SECTION II: PROGRAM'S STRATEGIC OBJECTIVES AND PERFORMANCE GOALS

1. In the table below, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program.

Column 2: List the performance goals for each strategic objective.

Column 3: For each performance goal, indicate how performance is being measured and progress toward meeting the goal. Specify if the strategic objective listed is new/revised or continuing, the data sources, the methodology and specific measurement approaches (e.g., numerator and denominator). Please attach additional narrative if necessary.

Note: *If no new data are available or no new studies have been conducted since what was previously reported, please complete columns 1 and 2 and enter "NC" (for no change) in column 3*.

Please note that all objective and performance goals are continuing.

(1) Strategic Objectives	**(2) Performance Goals for each Strategic Objective**	**(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)**
Objectives related to Reducing the Number of Uninsured Children		
1. Increase Awareness	1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.	Data Sources: CA Department of Health Services (DHS) Methodology: Analyze changes in number of eligible children in Medicaid in FFY 2001 and FFY 2002. Progress Summary: See narrative on page 12.
	1.2 Reduce the percentage of uninsured children in target income families that have family income above no-cost Medi-Cal.	Data Sources: "*The State of Health Insurance in California: Findings from the 2001 California Health Interview Survey"* (Brown, et al, UCLA 2002). Methodology: Analyze changes in number of eligible uninsured children during FFY 2002. Progress Summary: See narrative on page 13.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	1.3. Reduce the percentage of children using the emergency room as their usual source of primary care.	Data Sources: See progress summary. Methodology: See progress summary. Progress Summary: The Managed Risk Medical Insurance Board (MRMIB) is currently investigating alternative data sources for monitoring the changes in this measure. It is also accessing the utility of this measure as a predictor of the contribution the HFP has in lowering rates.
Objectives Related to SCHIP Enrollment		
2. Provide an application and enrollment process which is easy to understand and use.	2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.	Data Sources: Enrollment Contractors/Enrolled Entities Methodology: Review and survey of current materials. Progress Summary: See narrative on page 13.
3. Ensure that financial barriers do not keep families from enrolling their children.	3.1. Limit program costs to two percent of annual household income.	Data Sources: Internal Enrollment Data, program design data, survey data Methodology: Review and analysis. Progress Summary: See narrative on page 14.
4. Ensure the Participation of Community Based Organizations in Outreach/Education Activities.	4.1. Ensure that a variety of entities experienced in working with target populations are eligible for an application assistance fee.	Data Sources: MRMIB/DHS financial records Methodology: Summary of expenses for application assistance from State FY 01/02 Progress Summary: See narrative on page 14.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	4.2. Ensure that a variety of entities experienced in working with target populations and have subcontracts have input to the development of culturally and linguistically appropriate outreach and enrollment materials.	Data Sources: Outreach and Education Contracts/Enrolled Entity Survey Methodology: Review contract listing. Progress Summary: See narrative on page 14.
Objectives Related to Increasing Medicaid Enrollment		
Objectives Related to Increasing Access to Care (Usual Source of Care, Unmet Need)		
5. Provide a choice of health plans.	5.1. Provide each family with two or more health plan choices for their children.	Data Sources: Enrollment data from the HFP Administrative Vendor - Electronic Data Systems (EDS) Methodology: Data extract and reports from vendor database of percent of enrollment by county and number of health plans per county. Progress summary: See narrative on page 15.
6. Encourage the inclusion of traditional and safety net providers.	6.1. Increase the number of children enrolled who have access to a provider within their zip code.	Data Sources: Data from administrative vendor/provider locations from GeoAccess Methodology: Review change in penetration pre and post HFP implementation. Progress Summary: Approximately **0.14%** of total subscribers live in a zip code that has no provider, down from 6.8% in the previous reporting period.

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
	6.2. Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.	Data Sources: Health Plan Traditional & Safety Net Provider Report CPP Designations Methodology: Reports submitted by HFP Participating health plans on the number of children who have a Traditional and Safety Net provider as their PCP. Progress Summary: See narrative on page 15.
7. Ensure that all children with significant health needs receive access to appropriate services.	7.1. Maintain or improve the percentage of children with services.	Data Sources: HFP enrollment, CCS, County mental health data, and the *Health Status Assessment Project – First Year Results*. Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 15.
	7.2. Ensure no break in coverage as they access specialized services.	Data Sources: HFP enrollment, CCS, County mental health data Methodology: Review and analysis of mechanisms in place to serve children with significant health problems. Track complaints from children with special needs. Progress Summary: See narrative on page 15.
Objectives Related to Use of Preventative Care (Immunizations, Well Child Care)		

(1) Strategic Objectives	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify Data Sources, methodology, time period, etc.)
8. Ensure health services purchases are accessible to enrolled children.	8.1. Achieve year to year improvements in the number of children that have had a visit to a primary care physician during the year.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2001*.
	8.2 Achieve year to year improvements in the number of children who have had a child exam at appropriate interval.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2001*.
	8.3. Achieve year to year improvements in the number of children who have received immunizations by age 2 and age 13.	Data Sources: HEDIS Measures Methodology: Compiling HEDIS measure data in total and for selected demographic variables. Progress Summary: Please see attached report titled, *Quality Measurement Report 2001*.
Other Objectives		
9. Strengthen and encourage employer -sponsored coverage to maximum extent possible.	9.1 Maintain the proportion of children under 200% FPL who are covered under an employer based plan. Adjust for increased costs.	Data Sources: Survey performed by the University of California, San Francisco (UCSF). Methodology: Random sample of recent enrollees. Progress Summary: UCSF estimates crowd-out at 8%. Of this 8%, 75% indicated that they could not afford other insurance. These numbers indicate that crowd-out has not affected the HFP to any significant degree.

Narrative 1.1 Increase the percentage of Medi-Cal eligible children who are enrolled in the Medi-Cal program.

There has been an increase in the total number of children in Medi-Cal between June 2001 and June 2002. Most notable is a 41.67 % increase in the number of children in the Medicaid Expansion program. There was a slight increase in the number of children in the One-Month Bridge program.

Children Enrolled in Medi-Cal and One Month Bridge

	June 2001	June 2002	Change	Percent Change
Total Medicaid	2,744,428	3,017,209	272,781	9.93%
Regular Medicaid	2,711,756	2,970,920	259,164	9.55%
Medicaid Expansion	32,672	46,289	13,617	41.67%
One Month Bridge	2,153	2,219	66	3.07%

From Healthy Families Medicaid Expansion, Regular Medicaid, and One Month Bridge Eligibles Later Updates to the Data for the CHIP Quarterly Statistical Reporting on the CMS-64 21E, HCFA-64EC and CMS-21E 10/30/2002. Prepared by Fiscal Forecasting and Data Management Branch.

This increase in Medi-Cal enrollment of children can be attributed to the outreach efforts and the State's implementation of changes in the Medi-Cal program.

The DHS allocated $10 million in SCHIP funds to 21 counties in 2001-2002 to conduct HFP community based outreach and awarded $12 million to 55 community based school outreach contracts to enroll eligible children in HFP and Medi-Cal.

Effective January 1, 2001, Medi-Cal no longer requires a Quarterly Status Report (QSR). Without the QSR, eligibility redeterminations are done annually resulting in 12-month Continuous Eligibility for Children (CEC).

Effective July 1, 2002, the DHS implemented accelerated eligibility for children screened for Medi-Cal eligibility to have immediate access to medical, dental and vision care while the county social services departments determine Medi-Cal eligibility.

These efforts and changes have had a combined effect of making it easier for families and children to apply for and stay on Medi-Cal.

Narrative 1.2 Reduce the percentage of uninsured children in target income families that have family income above no cost Medi-Cal

Denominator- HFP eligible baseline (see Section III, Questions 2,4 and 5, pages 20-21, for a detailed description)

D = New estimated number of uninsured children in target income families
= 759,000

Numerator- Actual number of uninsured children insured under HFP during the reporting period.

N = Actual number of uninsured children insured under HFP during reporting period.
= 596,000

Progress toward goal- Estimated reduction in the percentage of uninsured children in target income families that have family income above no cost Medi-Cal:

P = N/D
= 79%

Narrative 2.1. Ensure Medi-Cal and HFP enrollment contractor provide written and telephone services spoken by target population.

Applicants can receive enrollment instructions, applications, and handbooks in ten languages. These languages include English, Spanish, Vietnamese, Khmer (Cambodian), Armenian, Cantonese, Korean, Russian, Hmong and Farsi. In addition, HFP has all correspondence, billing invoices and other program notification materials available in five languages. These languages include; English, Spanish, Chinese, Korean, and Vietnamese.

The toll-free HFP information line (1-800-880-5305) was established and is administered by the program's administrative vendor, EDS. Enrollment specialists offer HFP and Medi-Cal information, enrollment assistance and status of application.

The line is staffed by a team of operators proficient in the eleven designated languages in which campaign materials are published. The following table describes the frequency of calls by language.

Language	HFP/MCC Single Point of Entry		HFP/MCC Outreach	
	Program to Date	% of Total	Program to Date	% of Total
English	2,078,056	57.05%	852,654	69.37%
Spanish	1,289,213	35.39%	325,439	26.48%
Cantonese	121,089	3.32%	12,532	1.02%
Korean	73,665	2.02%	6,763	0.55%
Vietnamese	40,712	1.12%	15,591	1.27%
Armenian	22,711	0.62%	889	0.07%
Russian	7,647	0.21%	2035	0.17%
Farsi	4,635	0.13%	725	0.06%
Cambodian	2,839	0.08%	864	0.07%
Hmong	1,436	0.04%	1459	0.12%
Lao	569	0.02%	1	0.00%

In July 2001 a special toll free member services number (866-848-9166) was implemented to assist members with inquiries about their account, appeals, or to provide information to keep their account current (e.g., address change, etc). The HFP information and member services call lines operate Monday - Friday between 8 a.m. and 8 p.m. and on Saturday 8 a.m. and 5 p.m.

In addition to this performance measure, a survey of families who were eligible but not enrolled in the HFP showed that only 1.6% of these families were not enrolled due to paperwork being too difficult.

Narrative 3.1 Limit program costs to two percent of annual household income.

California continues to limit HFP costs to below two percent of annual household income. The following table represents the aggregate distribution of income and premiums for enrollees during the reporting period. The maximum weighted average program costs based on the mix of actual program enrollees as a percent of income was 1.4%.

This analysis assumes an average family size of four, 35.4% of subscribers receiving the $3/month discount for enrolling with a Community Provider Plan (please see narrative for 6.1 on the following page), and expending the maximum health copayment of $250. The $250 copayment equals 50 visits or prescriptions per year at $5 per visit. During the 2001/2002 benefit year, 0.1% of HFP members spent the maximum in copayments.

Aggregate Income and Premium Statistics

Countable Income	Percent of Subscribers	Average Annual Premium (assuming 35.4% take $3 discount)	Maximum Allowable Health Copayments	Maximum Total Program Cost	Average Annual Income	Maximum Program Cost as a Percent of Income
Under 150%(fpl)	28.7%	$143	$250	$393	$23,404	1.7%
Over 150%(fpl)	71.3%	$191	$250	$441	$33,516	1.3%

Narrative 4.1 and 4.2. Ensure the Participation of Community Based Organizations in Outreach and Education Activities.

Community-based organizations are an integral part of the HFP and Medi-Cal Program Outreach strategy. As of September 2002, 61.2% of applications received through the *Single Point of Entry* process were assisted by organizations that participated in the application assistance fee program. The most common type of community based organization serving as enrollment entities are insurance agents, medical service providers (clinics, providers, and hospitals), and community based programs. Medical service providers submit the largest number of applications to SPE compared to all other organizations. $5,000,000 in fees was paid to these community groups in State FY 01/02.

Due to the State's fiscal crisis, effective July 1, 2002, all advertising campaigns and outreach contracts with community based organizations were cancelled. Although this impacts some outreach efforts, the DHS has contracted with two additional organizations to train CAAs. These new contractors have helped the State to reduce the training request backlog and have trained CAAs in the Los Angeles area and more rural Northern California counties.

The recent addition of CAA training contractors has enabled the State to increase the number of CAA training sessions in the rural areas of Northern California. The contracts have also enabled the State to provide sessions in Chinese and Spanish. Many of the community based organizations serve designated target populations and have refined their strategies for working with diverse populations of the clients with whom they have a history in serving.

Narrative 5.1. Provide each family with two or more health plan choices for their children.

HFP offers a broad range of health plans for program subscribers. A total of 27 health plans participated in the program during the reporting period. Over 99% of subscribers have a choice of at least two health plans from which to select. The 1% of subscribers who have a choice of only one health plan mostly reside in rural areas of the state where access to health care services are limited. These subscribers are enrolled in exclusive provider organization plans (EPO) that provide a broad network of providers. In 36 of 58 counties, subscribers have a choice of up to 3 or more health plans. In 3 of these 36 counties, members can choose from up to 7 health plans. Ten health plans currently offer services to various portions of Los Angeles County.

Narrative 6.2 Increase the number of children enrolled who have access to a traditional and safety net provider as defined by MRMIB.

As an incentive to include traditional and safety net providers in their network, health plans with the highest percentage of traditional and safety net providers in their network are designated as a Community Provider Plan (CPP). Plans with the Community Provider Plan designation are offered at a $3 discount per child per monthly premium discount. Traditional and safety net providers are available in all areas of the state, and all HFP subscribers have access to them.

Seventeen of 27 participating health plans are designated as a Community Provider Plan (CPP) in at least one county. Of all HFP subscribers, 35.4% are enrolled in a CPP and receive a $3 discount.

Narrative 7.1 and 7.2 Ensure that all children with significant health needs receive access to appropriate services:

Children enrolled in the HFP are referred to the California Children's Services (CCS) Program or county mental health departments, depending upon their special health care needs. These referrals may originate with the health plans participating in the HFP, or from other sources such as schools or families. Reports submitted by participating plans indicated that 6,368 children were referred to the CCS program and that 1,072 children were referred to a county mental health program during the 2001/02 State fiscal year. The State has two administrative systems to facilitate the tracking of these children.

The State monitors access to services for children with special health care needs by 1) holding routine meetings with health, dental and vision plans and the CCS and county mental health programs; and 2) through follow-up on complaints received from subscribers. The routine meeting with plans and the programs allow the State and plans to discuss any arising or foreseeable barriers to access, and ways to eliminate these barriers. Newsletters were developed for county mental health programs to reinforce referral protocols for health plan/county mental health referrals and to provide county mental health departments with updates on the HFP. The California Institute of Mental Health in collaboration with the State developed these newsletters. During the reporting period, brochures were distributed to families to better educate them about the CCS and county mental health programs.

Results from the Health Status Assessment Project indicate that children with significant health needs have fewer problems accessing care and forego health care less frequently than they did before enrollment in the HFP. Those families reporting difficulty accessing care declined from 29.0% to 23%. Those families reporting that they have forgone care declined from 25.0% to 14.9%. For more information regarding the Health Status Assessment Project, please see attached report titled *Health Status Assessment Project – First Year Results*.

2. How are you measuring the access to, or the quality or outcomes of care received by your SCHIP population? What have you found?

MRMIB obtains information on quality of care through health and dental plan reporting requirements and subscriber surveys. The sources of information used to obtain data on the quality of care delivered through health, dental and vision plans includes the following:

Fact Sheets
Fact Sheets are submitted by each health, dental and vision plan interested in participating in the HFP. The questions that are included in the Fact Sheet request information about the organization of the plans and the provision of health, dental and vision care services. Some of the specific areas that are addressed include access to providers, access to plan services, including customer service, standing with regulatory entity or accrediting body, and process for handling member grievances. Fact Sheets are submitted by the plans annually.

Annual Quality of Care Reports
Each year, health and dental plans are required to submit quality of care reports based on HEDIS® and a 120-day health (and dental) assessment measure. The HEDIS® reports for health plans focus on the number of children who have been immunized and on the number of children receiving well child visits. Because preventive care is vital to young children and is the cornerstone of care provided through the HFP, the annual quality of care reports provide an indication of how well a particular plan is providing health or dental care to members. A copy of the report is attached .

California Children's Services (CCS) and Mental Health Referral Reports
The CCS and Mental Health Referral Reports were implemented in FFY 2000 to monitor the access that eligible children have to CCS and county mental health services. On a quarterly basis, plans are required to report the number of children referred to these services. The numbers reported by plans are compared with the estimates of children expected to require CCS and county mental health services to determine whether there is adequate access to these services.

Cultural and Linguistics Services and Group Needs Assessment Reports
These reports allow staff to monitor how special needs of HFP subscribers related to language access, and culturally appropriate services are being met. The Cultural and Linguistic Services Report outlines how plans will provide culturally and linguistically appropriate services to subscribers. Specific information obtained for the report included:

- How plans assign subscribers to culturally and linguistically appropriate providers
- How plans provide interpreter services to subscribers
- How plans provide culturally and linguistically appropriate marketing materials
- A list of written materials plans make available in languages other than English

Participating plans were also required to do a Group Needs Assessment Report. The Group Needs Assessment Report identifies the unique perspectives of subscriber based on their cultural beliefs. Participating plans conducted an assessment of their subscribers to determine:

- Health-related behaviors and practices
- Risk for disease, health problems and conditions
- Knowledge, attitudes, beliefs and practices related to access and use of preventive care
- Knowledge, attitudes, beliefs and practices related to health risk
- Perceived health, health care and health education needs and expectations
- Cultural beliefs and practices to alternative medicine

The assessment included an evaluation of community resources for providing health education and cultural and linguistic services and the adequacy of the network. Based on the results of the assessment, each plan is required to develop a program to address the needs identified in the group needs assessment. Participating plans submitted their first group needs assessment reports in June 2001.

Five major findings that participating plans discussed in their GNA report included:

1. HFP subscribers have similar health and dental risks compared to those reported in national, state and local studies. Educational materials sought by HFP subscribers also match these identified risks.
2. HFP subscribers may not fully understand how to access plan services or their rights.
3. Language differences present a barrier to health care for some individual HFP subscribers.
4. HFP providers need training to increase their cultural competency skills.
5. Community-based organizations (CBOs) can assist plans in providing culturally and linguistically appropriate services.

Participating plans also reported on their ongoing and proposed efforts to address their GNA findings. These efforts include:

- Targeting educational efforts addressing obesity/Diabetes Type II, asthma, immunizations, infection control, oral and eye health, and bicycle safety education programs;
- Increasing subscriber knowledge of the managed care system and member rights;
- Improving plan infrastructure so that it is responsive to members' linguistic and cultural health services needs; and
- Involving plan members, plan providers and the community in the development and provision of culturally and linguistically appropriate health services.

Although plans have identified certain cultural and linguistic needs and activities to address those needs, these needs do not constitute a systemic barrier to provision of health care services. The 2001 Quality Measurement Report suggests that disparities in access to health care across ethnic and linguistic groups are not present in the HFP. For more information regarding these results, see attached report titled *Quality Measurement Report – 2001.*

Member Surveys

MRMIB uses two types of member surveys to monitor quality and service. During open enrollment, all subscribers are given a plan disenrollment survey. The survey requests information on why members decided to switch plans during open enrollment. Questions on the survey address plan quality, cost, adequacy of the provider network, and access to primary care providers. The comparison of disenrollment trends and results from the disenrollment surveys provide another tool for monitoring plan performance. For further information, please see the attached Open Enrollment Survey report.

Consumer satisfaction surveys, for both health and dental plans, are conducted each year. The surveys are conducted in five languages (English, Spanish, Chinese, Korean, and Vietnamese) and are based on the Consumer Assessment of Health Plans Survey (CAHPS® 2.0H). Responses from the surveys provide information on access to care (including specialty referrals), quality of provider communication with subscribers, and ratings of providers, health and dental plans and overall health and dental care. Significant findings include:

- On a scale of 0–10 with "10" being the best care and "0" being the worst, 80 percent of families gave their health care, health plan, personal doctor (or nurse) and specialist a rating of at least an 8. The aspect of care receiving the highest percentage of families giving high ratings was in the overall rating of the health plan. Eighty-four percent of families rated their plan an 8, 9 or 10.
- The percentage of families giving their health plan high ratings ***increased*** in 2001. In the 2001 survey, 85 percent of families gave their plan a high rating. In the 2000 survey, 83.2 percent of families gave their plan a high rating.
- 87 percent of families responded positively when asked questions about how well doctors communicate.

For additional information, please see attached report.

In January 2002, the MRMIB conducted the first ever Dental CAHPS® Survey to measure subscriber experiences with dental care and to provide existing and potential HFP applicants with information about their dental plan options. The MRMIB worked with RAND (a member of the CAHPS® consortia) to complete the survey instrument and prepare it for the field. Significant findings for the program include:

- Approximately 64 percent of families responded positively when asked questions rating their dentist's care, dental plan, and personal dentist.
- 74 percent of families responded positively when asked questions rating their specialist.
- 81 percent of families responded positively when asked questions rating how well their dentist communicates.
- 79 percent rated the responded positively when asked questions rating courteousness and helpfulness of office staff.

For further information, please see attached report.

Subscriber Complaints

MRMIB receives direct inquiries and complaints from HFP applicants. Ninety percent of the inquiries are received via correspondence and ten percent through phone calls. All HFP inquiries and complaints are entered into a data file that is categorized by the subscriber's plan, place of residence, the families' primary languages and type of request. This data enables staff to track complaints by plan and to: 1) monitor access to medical care by plan, 2) evaluate the quality of health care being rendered by plan, 3) evaluate the effectiveness of plans in processing complaints, and 4) monitor the plan's ability to meet the linguistic needs of subscribers.

3. What plans does your SCHIP program have for future measurement of the access to, or the quality or outcomes of care received by your SCHIP population? When will data be available?

A system is in place to review quality of care, as measured through the currently available quality measures, by certain demographic variables. These variables include age, language, ethnicity, and location. This system will provide the ability to identify quality-related issues (e.g., disparities in immunization rates, consumer satisfaction, etc.) that may arise with any demographic group represented in the program. HEDIS® and CAHPS® data will be analyzed for year-to-year trend analysis.

MRMIB, with past financial support from the California HealthCare Foundation (CHCF), convened a Quality Improvement Work Group in 1998 to develop specific recommendations for implementing a set of quality initiatives for the HFP. Most of the recommendations made by the Group were implements by MRMIB. These recommendations focused primarily on collecting quality information from health and dental plans.

MRMIB will be reconvening Quality Improvement Work Group to review the results of their recommendations and to address new issues relating to quality. The key issues that MRMIB would like the Work Group to explore include:

1. Should MRMIB adopt new HEDIS® measures released since the Work Group made its initial recommendations or continue collecting the current list of measures? If new measures are included in the HFP quality measurement set, should health plans be required to collect all measures each year or should MRMIB rotate measures?

2. MRMIB is interested in obtaining more information on the services received by HFP subscribers. MRMIB is planning to collect health and dental plan encounter data.

3. Should MRMIB set performance targets for preventive services and require plans that do not meet these targets to submit corrective action plans?

4. Since the Work Group submitted its recommendations regarding the use of NCQA accreditation as a condition of contracting of HFP, NCQA has changed (or made more clear) its policy regarding the accreditation of SCHIP product lines?

5. What steps should MRMIB take in developing incentives for quality and for promoting continuous quality improvement among health and dental plans?

The Work Group is expected to complete its recommendations on these issues by August 2003.

4. Have you conducted any focused quality studies on your SCHIP population, e.g., adolescents, attention deficit disorder, substance abuse, special heath care needs or other emerging health care needs? What have you found?

The Health Status Assessment Project is a three-year longitudinal survey that will allow MRMIB to evaluate the health status of children newly enrolled in the HFP. The project examines the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance. The project is being conducted by MRMIB in partnership with researchers at the Center for Child Health Outcomes, Children's Hospital and Health Center, San Diego. Financial support is provided by the David and Lucile Packard Foundation.
Key findings from results after one year of enrollment are:

- The HFP meaningfully improved the health-related quality of life for children in the greatest need;
- The HFP had a positive impact on children with chronic health conditions;
- Meaningful improvements in health-related quality of life were achieved within ethnic demographics;
- The HFP improved access to care for its members;
- Children in the poorest health missed less school and improved school performance due to enrollment in the HFP; and
- Families participating in the HFP are excited about the program and are willing to participate.

For more information regarding the Health Status Assessment Project, please see attached report titled *Health Status Assessment Project – First Year Results*.

5. Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here and summarize findings.

- Quality Measurement Report 2001
- 2002 Consumer Assessment of Health Plans Survey
- 2002 Consumer Assessment of Dental Plans Survey
- 2002 Open Enrollment Report
- Health Status Assessment Year 1 Report
- Why Eligible Children Lose or Leave SCHIP – NASHP Study
- Healthy Families Program Cultural and Linguistic Group Needs Assessment Report

SECTION III: ASSESSMENT OF STATE PLAN AND PROGRAM OPERATION

ENROLLMENT

1. ***Please provide the Unduplicated Number of Children Ever Enrolled in SCHIP in your State for the reporting period. The enrollment numbers reported below should correspond to line 7 in your State's 4th quarter data report (submitted in October) in the SCHIP Statistical Enrollment Data System (SEDS).***

81,089	SCHIP Medicaid Expansion Program (SEDS form 64.21E)	775,905	Separate Child Health Program (SEDS form 21E)

2. ***Please report any evidence of change in the number or rate of uninsured, low-income children in your State that has occurred during the reporting period. Describe the data source and method used to derive this information.***

California is now using the California Health Interview Survey (CHIS) as its primary source of data for the number of uninsured. This new data source was adopted because it is believed to be more precise than the estimates based upon CPS data. Results from the first survey were released in June 2002. The survey is scheduled to be conducted every two years.

Between 2000 and 2001, the estimated number of uninsured children eligible for either HFP or Medi-Cal fell from approximately 1.3 million to approximately 656,000. The dramatic change in the estimate is due to the change in the methodology used for the estimates. The estimate of 1.3 million was based on the CPS data that used small sample sizes, reducing the estimate's precision. The estimate of 656,000 is based on a survey that was specifically designed to estimate the number of uninsured individuals in California and used a larger sample size than that obtained from the CPS.

(States with only a SCHIP Medicaid Expansion Program, please skip to #4)

3. ***How many children do you estimate have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.***

While the State does not actively collect data estimating the impact of outreach and enrollment simplification, the State believes outreach and enrollment simplification both play a major role in Medi-Cal's continuing increase in enrollment.

4. ***Has your State changed its baseline of uncovered, low-income children from the number reported in your previously submitted Annual Report?***

Note: The baseline is the initial estimate of the number of low-income uninsured children in the State against which the State's progress toward covering the uninsured is measured. Examples of why a State may want to change the baseline include if CPS estimate of the number of uninsured at the start of the program changes or if the program eligibility levels used to determine the baseline have changed.

	No, skip to the Outreach subsection, below		
X	Yes, please provide your new baseline	759,000	And continue on to question 5

The new baseline is calculated by combining the number of children estimated to be eligible and not enrolled in the HFP with the number of children enrolled in the HFP at the time CHIS was conducted. CHIS estimates that 301,000 children were eligible but not enrolled in the HFP as of October 1, 2001. As of October 1, 2001 CHIS reported 458,000 children were enrolled in the HFP.

In addition to the number of children eligible for SCHIP, CHIS also found that 355,000 children were eligible but not enrolled in Medi-Cal and another 180,000 children were uninsured who may have been income eligible for the HFP and Medicaid but who were ineligible and not enrolled because of immigration status.

5. On which source does your State currently base its baseline estimate of uninsured children?

_____ The March supplement to the Current Population Survey (CPS)

X A State-specific survey

_____ A statistically adjusted CPS

_____ Another appropriate source

A. What was the justification for adopting a different methodology?

California is now using the CHIS as its primary source of data for baseline calculations. This new data source was adopted because it is believed to be more precise than the estimates based upon CPS data. Results from the first survey were released in June 2002. The survey is scheduled to be conducted every two years.

B. What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Provide a numerical range or confidence intervals if available.)

CHIS was designed to specifically measure various aspects of health insurance in California and utilizes a large, inclusive survey sample. Due to CHIS' design and mission, California has greater confidence in the precision of CHIS results than estimates compiled from CPS data. CHIS surveyed approximately 74,000 Californians in six different languages. The six languages were English, Spanish, Chinese, Korean, Vietnamese, and Khmer.

C. Had your State not changed its baseline, how much progress would have been made in reducing the number of low-income, uninsured children?

If the baseline had not changed, California would have achieved a 182% penetration of the March 2000 Evaluation original baseline estimate of **328,000.** It is important to keep in mind that a significant increase in the baseline between the March 2000 evaluation and FFY 2002 was due to expansion in eligibility to 250% FPL. As indicated on page 13, HFP has enrolled approximately 79% of children eligible for the program based on the new baseline estimates.

OUTREACH

1. How have you redirected/changed your outreach strategies during the reporting period?

Due to the State's fiscal crisis, effective July 1, 2002, all advertising campaigns and outreach contracts with community based organizations were cancelled. Although this impacts some outreach efforts, the DHS has contracted with two additional organizations to train CAAs. These new contractors have helped the State to reduce the training request backlog and have trained CAAs in the Los Angeles area and more rural Northern California counties.

2. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

In the past, the education and outreach campaign has consisted of a combination of advertising, collateral materials, public relations, community and school-based outreach, and certified application assistance. All of these efforts reinforced each other in targeting eligible children for the HFP and Medi-Cal for Children Programs. The CAAs continue to be the primary outreach vehicle with a consistent average of over 60% of all applications for HFP and Medi-Cal Programs being assisted by a CAA. For more application information, please see the 2002 Single Point of Entry Fact Book available at www.mrmib.ca.gov – Special Reports.

To initiate the relationship between a CAA and new applicants, the HFP administrative vendor provides CAA referral services to families who need assistance in completing their application. This information is available on-line via the HFP website (www.healthyfamilies.ca.gov – Find An Application Assistant in Your Area) or by calling the toll-free HFP information number (1-800-880-5305).

3. ***Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants, and children living in rural areas)? How have you measured effectiveness?***

The recent addition of CAA training contractors has enabled the State to increase the number of CAA training sessions in the rural areas of Northern California. The contracts have also enabled the State to provide sessions in Chinese and Spanish. Many of the community based organizations serve designated target populations and have refined their strategies for working with diverse populations of the clients with whom they have a history in serving.

SUBSTITUTION OF COVERAGE (CROWD-OUT)

(All States must complete the following 3 questions)

1. ***Describe how substitution of coverage is monitored and measured.***

Crowd-out is monitored through the eligibility determination process and the collection of employer-sponsored insurance at the time of application data. Applicants are required to answer questions about each child's previous health coverage. Children who received employer-based health coverage 90 days prior to application are not eligible for the HFP, unless they qualify for specific exemptions. These exemptions include:

- The person or parent providing health coverage lost or changed jobs;
- The family moved into an area where employer-sponsored coverage is not available;
- The employer discontinued health benefits to all employees;
- Coverage was lost because the individual providing the coverage died, legally separated, or divorced;
- COBRA coverage ended; or
- The child reached the maximum coverage of benefits allowed in current insurance in which the child is enrolled.

2. ***Describe the effectiveness of your substitution policies and the incidence of substitution. What percent of applicants, if any, drop group health plan coverage to enroll in SCHIP?***

Researchers from the University of California, San Francisco Institute for Health Policy Studies examined the level of crowd-out occurring in the HFP. Their study concluded that up to 8% of new applicants had employment-related insurance within the 3 months prior to enrolling in the HFP. The researchers found that the highest rate of "crowd-out" was in the lower income group (below 200%) and that the single largest reason parents gave for dropping employer-sponsored coverage was that it was unaffordable. More than a quarter of the "crowd-out" group reported paying more than $75 per month. For more information, please see attached report titled, *"Crowd-out in the Healthy Families Program: Does it Exist."*

3. ***At the time of application, what percent of applicants are found to have insurance?***

The HFP does not currently collect data that would indicate the percentage of applicants that have insurance at the time of application. However, the HFP continues to exclude children from enrollment if they have had employer-sponsored health insurance in the last three months prior to their application, unless they meet one of five exceptions listed in question 1.

(States with separate child health programs over 200% of FPL must complete question 4)

4. ***Identify your substitution prevention provisions (waiting periods, etc.).***

Please see response to Question #3.

(States with a separate child health program between 201% of FFP and 250% of FPL must complete question 5.)

5. ***Identify the trigger mechanisms or point at which your substitution prevention policy is instituted.***

The HFP does not maintain any trigger mechanisms. The HFP substitution prevention policy is continually enforced through program eligibility requirements.

(States with waiting period requirements must complete question 6. This includes states with SCHIP Medicaid expansion programs with section 1115 demonstrations that allow the State to impose a waiting period.)

6. ***Identify any exceptions to your waiting period requirement.***

See response to question #3.

COORDINATION BETWEEN SCHIP AND MEDICAID

(This subsection should be completed by States with a Separate Child Health Program)

1. ***Do you have the same redetermination procedures to renew eligibility for Medicaid and SCHIP (e.g., the same verification and interview requirements)? Please explain.***

The redetermination process for Medicaid is separate from SCHIP. For Medicaid, each county welfare department mails a redetermination form to the applicant one month prior to the child's anniversary date. The form must be returned before the end of the annual redetermination month. If the child is found to be eligible for Medi-Cal, the child will continue to be enrolled in Medi-Cal for an additional twelve months. If the child is not eligible for Medi-Cal, the redetermination form is sent to SPE for HFP eligibility determination as long as there is parental consent. Failure to provide the completed annual redetermination form results in the discontinuance of benefits. However, should the beneficiary complete the annual redetermination required within 30 days of discontinuance, the discontinuance may be rescinded and benefits restored without a break in coverage.

For the HFP, the Administrative Vendor sends a preprinted customized AER packet to HFP applicants 60 days prior to the child's anniversary date to verify and update household information and request income documentation.

Although the redetermination process for Medicaid and SCHIP are separate, the income deductions and documentation used by both programs are the same.

2. ***Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes. Have you identified any challenges? If so, please explain.***

In SCHIP, if a subscriber is determined to be ineligible due to income (too low) at AER and the applicant has requested Medicaid screening, the AER application is forwarded to the county welfare department (CWD) in the county of the child's residence for a Medicaid eligibility determination. To improve the coordination between the two programs and ensure continuity of care, the State grants two additional months of HFP "bridge coverage" while the application is being processed for Medi-Cal eligibility. This new process began on July 1, 2002.

As part of this new HFP bridge, California has also created a detailed transmittal sheet which accompanies each application it forwards to the CWD. This sheet provides detailed subscriber information such as, the income determination used to screen for no-cost Medi-Cal eligibility for each individual subscriber, the household composition and family relationships, and the unique identification number assigned to each child on the State's Medi-Cal Eligibility Data System (MEDS). The unique Client Index Number (CIN) provides California the ability to track HFP and Medi-Cal applications, enrollment and eligibility status of children in either program or those being transferred between programs. If the CWD determines that a child is not eligible for no-cost Medi-Cal and may be eligible for the HFP, the transmittal sheet is returned to the Single Point of Entry with the application and with any subsequent documentation for a HFP determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

There is a significant overlap in the managed care networks for HFP and for Medi-Cal. Of the 27 health plans offered by the HFP, 22 participate in the Medi-Cal program. Approximately 54% of HFP subscribers are enrolled in plans that participate in both programs.

ELIGIBILITY REDETERMINATION AND RETENTION

1. What measures are being taken to retain eligible children in SCHIP? Check all that apply.

X	Follow-up by caseworkers/outreach workers
X	Renewal reminder notices to all families, *specify how many notices and when notified* Subscribers receive an AER Courtesy call 15 days after the AER package was sent to confirm receipt. A reminder postcard is sent after 30 days if package is not received.
	Targeted mailing to selected populations, *specify population*
	Information campaigns
X	Simplification of re-enrollment process, *please describe* Custom pre-printed re-enrollment package in 10 languages
X	Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, *please describe* A survey is conducted during the courtesy call to determine if families have received their AER package, need assistance completing the package or the reason they will not be returning the package for a re-determination. AER courtesy call 15 days after package sent to confirm receipt and a reminder postcard is sent after 30 days if package is not received.
	Other, *please explain*

2. Which of the above measures have been effective? Describe the data source and method used to derive this information.

Currently the HFP does not have data measuring the effectiveness of measures taken to retain eligible children. The HFP has observed a small decrease in the rate of AER packages returned incomplete and a slight increase in the rate of AER packages not returned. However, these changes were too small to be significant.

3. Has your State undertaken an assessment of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured, how many age-out, or how many move?) If so, describe the data source and method used to derive this information.

The HFP assesses and reports a wide variety of enrollment and disenrollment related information on the MRMIB website (www.mrmib.ca.gov) on a monthly basis. This information also details the number and reason children who disenroll from the HFP. These reasons include children who do not re-enroll at their AER, not eligible at AER, age out of the program (i.e., reach age 19), and those who obtain other insurance at AER.

According to monthly enrollment reports, during the period of this report, 305,598 new children were enrolled in the HFP. A total of 910,003 children were "ever enrolled" in the program. During this same period, 72,952 children (8% of those children ever enrolled) did not re-enroll in the HFP during their AER. An additional 38,283 children (4% of those children ever enrolled) were determined to be no longer eligible during their AER. A total of 11,508 children reached the age of 19 (1% of those children ever enrolled).

Although the HFP does not capture all types of private insurances a child may have at their AER, the number of children found to have no-cost Medi-Cal and employer sponsored insurance is reported. A total of 11,779 children (1% of those children ever enrolled) obtained other health insurance at their AER. This includes 10,272 children enrolled in no-cost Medi-Cal and 1,507 enrolled in employer sponsored insurance.

In addition, the National Academy for State Health Policy (NASHP) conducted a study to learn more about families whose SCHIP coverage lapsed. Results showed that approximately two-thirds (61%) of the families identified in the State's records as "lapsed" gave different accounts of their child's exit from SCHIP. These parents stated their children left for different reasons – reason that likely make them ineligible for the program.

Of those families with lapsed coverage, 51% stated their child received private insurance, 26% stated they did not re-enroll because of a change in income made them ineligible, 13% reported their child received coverage under the Medi-Cal Program, 4% stated their child was no longer eligible because of age and 5% gave other reasons. These numbers for California, when compared to the other states, were similar.

COST SHARING

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found?

The HFP conducts two surveys of those families whose children are disenrolled from the Program due to non-payment of premiums. The first is a postcard survey which is mailed to every applicant after their child(ren)'s disenrollment from the Program for non-payment of premium. This survey includes questions about premiums and the cost of the Program. The applicant is asked to indicate which of the following reason best describes the reason they did not pay their premium: 1) can not afford payment, 2) lost invoices, 3) never received invoice, and 4) forgot to pay premium.

The second survey is in conjunction with the non-payment courtesy call initiated by an HFP operator 10 days prior to disenrollment from the Program for non-payment of premium. During this call, the applicant is reminded that a premium payment is necessary in order to keep their child enrolled in the Program. If the applicant indicates they will not be making the payment, the HFP operator attempts to establish the reason why the applicant is not able to make the payment. These reasons include, "Can not afford the premiums".

From these surveys, the HFP has concluded that it is often the case that applicants that want to disenroll their child frequently quit paying their premium rather than providing the HFP with formal notice of disenrollment. Both these surveys are on a voluntary basis, however, based on both surveys it appears that only a very small percentage of those applicants who do respond are disenrolling from the Program because they can not afford to the cost of the monthly premiums.

In addition, the NASHP conducted a Retention and Disenrollment study in seven states, including California. The study consisted of a survey, conducted in the summer of 2001, and six focus groups, conducted in the winter of 2001. The study focused on two (2) groups of families: those with current subscribers who had been enrolled in the HFP for at least six months (416 families in California) and those families with subscribers whose coverage lapsed and were terminated for either not completing their annual renewal process or not paying their monthly premiums (293 families in California).

Of those families with lapsed coverage, 115 families were terminated due to non-payment of premiums. 36% of those families stated that they did not have the money to pay premiums due to the loss of income or employment. These families most likely were now eligible for no-cost Medi-Cal due to the change in their household income and situation(s). Most families (86% of the families with lapsed coverage) stated the premiums were reasonable and did not object to paying monthly premiums.

2. Has your State undertaken any assessment of the effects of cost sharing on utilization of health services in SCHIP? If so, what have you found?

The State has not conducted an assessment on the effect of cost sharing on utilization of health services. However, many services provided in the HFP do not require copayments. The program was designed with this feature to eliminate a potential barrier to services. Preventative health and dental services and all inpatient services are provided without copayment. Copayments are also not required for services provided to children through the California Children's Services Program and the county mental health departments for children who are Seriously Emotionally Disturbed (SED).

FAMILY COVERAGE PROGRAM UNDER TITLE XXI

1. Does your State offer family coverage through a family coverage waiver as described in 42 CFR §457.1010?

____ Yes, briefly describe program below and continue on to question 2.

__x__ No, skip to the Premium Assistance Subsection.

California does not offer family coverage at this time. In January 2002, California's SCHIP 1115, which would allow the use of SCHIP funds to cover uninsured parents of children enrolled in the HFP and/or Medi-Cal, was approved. However, State budget constraints have not allowed California to fund parental coverage in the HFP during the 2002-03 fiscal year. Upon receipt of approved funding, the HFP is prepared to implement parental coverage within six weeks of that approval.

2. Identify the total State expenditures for family coverage during the reporting period.

NA

3. Identify the total number of children and adults covered by family coverage during the reporting period. (Note: If adults are covered incidentally they should not be included in this data.)

_____ Number of adults ever enrolled during the reporting period

_____ Number of children ever enrolled during the reporting period

4. What do you estimate is the impact of family coverage on enrollment, retention, and access to care of children?

5. How do you monitor cost effectiveness of coverage? What have you found?

PREMIUM ASSISTANCE PROGRAM UNDER SCHIP STATE PLAN

1. Does your State offer a premium assistance program through SCHIP?

Note: States with family coverage waivers that use premium assistance should complete the Family Coverage Program subsection. States that do not have a family coverage waiver and that offer premium assistance, as part of the approved SCHIP State Plan should complete this subsection and not the previous subsection.

____ Yes, briefly describe your program below and continue on to question 2.

__**X**__ No, skip to Section IV.

2. ***What benefit package does your state use? e.g., benchmark, benchmark equivalent, or secretary approved***

3. ***Does your state provide wrap-around coverage for benefits?***

4. ***Identify the total number of children and adults enrolled in your premium assistance SCHIP program during the reporting period (provide the number of adults enrolled in premium assistance even if they were covered incidentally and not via the SCHIP family coverage provision).***

   _____ Number of adults ever enrolled during the reporting period

   _____ Number of children ever enrolled during the reporting period

5. ***Identify the estimated amount of substitution, if any, that occurred as a result of your premium assistance program.***

6. ***Indicate the effect of your premium assistance program on access to coverage.***

7. ***What do you estimate is the impact of premium assistance on enrollment and retention of children?***

SECTION IV: PROGRAM FINANCING FOR STATE PLAN

1. Please complete the following table to provide budget information. Describe in narrative any details of your planned use of funds below. Note: This reporting period = Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02). If you have a combination program you need only submit one budget; programs do not need to be reported separately.

COST OF APPROVED SCHIP PLAN

	Reporting Period	Next Fiscal Year	Following Fiscal Year
Benefit Costs			
Insurance payments			
Managed Care	554,828,704	674,606,208	775,147,014
Per member/Per month rate @ # of eligibles			
Fee for Service	91,012,392	139,036,499	176,132,453
Total Benefit Costs			
(Offsetting beneficiary cost sharing payments)	-30,691,695	-41,211,563	-45,457,251
Net Benefit Costs	**$615,149,401**	**$772,431,144**	**$905,822,216**
Administration Costs			
Personnel			
General Administration	44,693,106	54,422,488	59,770,290
Contractors/Brokers (e.g., enrollment contractors)			
Claims Processing			
Outreach/Marketing costs	28,533,294 (1)	5,718,750	0
Other			
Total Administration Costs	**73,226,400 (2)**	**60,141,238**	**59,770,290**
10% Administrative Cap (net benefit costs ÷ 9)	**68,349,933**	**85,825,683**	**100,646,913**
Federal Title XXI Share	**454,190,353**	**541,172,048**	**627,635,129**
State Share	**234,185,448**	**291,400,334**	**337,957,377**
TOTAL COSTS OF APPROVED SCHIP PLAN	**688,375,801**	**832,572,382**	**965,592,506**

(1) For FFY 02, $15,722,260 in outreach cost are exempt from the 10% cost ceiling, for exemption of outreach expenditures from the FFY 98 retained allotment.

(2) For FFY 02, costs subject to the 10% cost ceiling are only $57,504,140 after adjusting for exemption of outreach expenditures from the FFY 98 retained allotment.

2. What were the sources of non-Federal funding used for State match during the reporting period?

- **X** State appropriations
- **X** County/local funds
- ____ Employer contributions
- **X** Foundation grants
- ____ Private donations (such as United Way, sponsorship)
- ____ Other (specify)

SECTION V: 1115 DEMONSTRATION WAIVERS (FINANCED BY SCHIP)

1. If you do not have a Demonstration Waiver financed with SCHIP funds skip to Section VI. If you do, please complete the following table showing whom you provide coverage to.

California has an approved 1115 waiver to provide coverage to parents of children enrolled in Medi-Cal or the HFP. However, the State has not had sufficient State funds to implement the waiver.

	SCHIP Non-HIFA Demonstration Eligibility					HIFA Waiver Demonstration Eligibility				
Children	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL
Parents	From	—	% of FPL to	—	% of FPL	From	0%	% of FPL to	200 %**	% of FPL
Childless Adults	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL
Pregnant Women	From	—	% of FPL to	—	% of FPL	From	—	% of FPL to	—	% of FPL

*** Parents are eligible for the HIFA waiver program if a) they have a child enrolled or eligible for Medicaid or SCHIP and b) if the parents are eligible for Medicaid. The implementation of the waiver demonstration has been suspended due to the State's budgetary constraints.*

2. Identify the total number of children and adults ever enrolled your demonstration SCHIP program during the reporting period.

_____ Number of **children** ever enrolled during the reporting period in the demonstration

_____ Number of **parents** ever enrolled during the reporting period in the demonstration

_____ Number of **pregnant women** ever enrolled during the reporting period in the demonstration

_____ Number of **childless adults** ever enrolled during the reporting period in the demonstration

3. What do you estimate is the impact of your State's SCHIP section 1115 demonstration waiver is on enrollment, retention, and access to care of children?

4. Please complete the following table to provide budget information. Please describe in narrative any details of your planned use of funds. Note: This reporting period (Federal Fiscal Year 2002 starts 10/1/01 and ends 9/30/02).

COST PROJECTIONS OF DEMONSTRATION (SECTION 1115 or HIFA)	**Reporting Period**	**Next Fiscal Year**	**Following Fiscal Year**
Benefit Costs for Demonstration Population #1 (e.g., children)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #1			
Benefit Costs for Demonstration Population #2 (e.g., parents)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #2			
Benefit Costs for Demonstration Population #3 (e.g., pregnant women)			
Insurance Payments			
Managed care			
per member/per month rate @ # of eligibles			
Fee for Service			
Total Benefit Costs for Waiver Population #3			
Total Benefit Costs			
(Offsetting Beneficiary Cost Sharing Payments)			
Net Benefit Costs (Total Benefit Costs - Offsetting Beneficiary Cost Sharing Payments)			
Administration Costs			
Personnel			
General Administration			
Contractors/Brokers *(e.g., enrollment contractors)*			
Claims Processing			
Outreach/Marketing costs			
Other *(specify)*			
Total Administration Costs			
10% Administrative Cap (net benefit costs ÷ 9)			
Federal Title XXI Share			
State Share			
TOTAL COSTS OF DEMONSTRATION			

SECTION VI: PROGRAM CHALLENGES AND ACCOMPLISHMENTS

1. Please provide an overview of what happened in your State during the reporting period as it relates to health care for low income, uninsured children and families. Include a description of the political and fiscal environment in which your State operated.

During the past fiscal year, California received approval of our HIFA waiver and was poised to expand the HFP to cover parents of children who were enrolled in or eligible for the HFP or Medi-Cal. Unfortunately, California, like many other states, experienced a down-turn in the economy resulting in reduced revenues and a projected budget shortfall of over $20 billion. As a result, the Governor was unable to sustain a funding augmentation that the State Legislature had added to the Budget Bill to fund an October 2002 implementation of the parental coverage expansion. In his budget address, the Governor did reaffirm his support for the expansion of coverage to parents.

The Governor has made getting health coverage for all children a priority in his administration, and as such none of the children's programs were significantly affected by the budget shortfall. The budget shortfall has affected the State's outreach efforts for the program. The outreach budget was trimmed from $31 million to approximately $10 million. Media campaigns and contracts to local Community based organizations and schools for outreach has been eliminated. However, reimbursements to CAAs have been maintained, and enrollment continues to remain strong in the program.

In an effort to backfill the gap that has been created by the elimination of key outreach efforts, the California Association of Health Plans and the California Teacher's Association have joined forces to involve and educate teachers in an outreach project aimed at getting school children insured. Teachers will be provided with education and on-site training about affordable health coverage programs so that they will then be able to distribute and provide information to parents. In addition to these efforts, the 100% Campaign (a coalition of children advocates) has been working with the California Small Business Association in the State to inform employers who do not provide health insurance for dependents about health insurance programs for children. Employers are being encouraged to share and distribute information to their employees and work with local community based organizations that can help their employees fill out applications.

2. During the reporting period, what has been the greatest challenge your program has experienced?

Moving a family seamlessly from Medi-Cal to the HFP has been our greatest challenge. The Medi-Cal enrollment process is decentralized and involves 58 separate and unique county entities resulting in variations in the application of program processes and interpretation of program policies and procedures. As counties redirect scarce resources to higher priority projects due to the budget crisis, efforts by the State and counties to address these issues have been slowed.

3. During the reporting period, what accomplishments have been achieved in your program?

The program had several accomplishments during the reporting period.

Overall Positive Effect of the Program on Access to Care and the Health Status of Enrolled Children. Results show that children entering the HFP who were in the poorest health reported fewer problems with obtaining a personal physician after one year in the program. For the families of these children, the results also show a decrease in the number of families reporting that these children had problems with getting care or foregoing needed care for their children.

The coverage provided by the HFP made remarkable improvements in the health status of children who were in poor health upon enrollment in the HFP. Researchers from the Health Status Assessment Project found that after one year in the HFP these children:

- Gained astounding improvement in physical and psychosocial health status equal to the level of chronically ill children receiving excellent health care
- Experienced fewer sick days and missed fewer days of school
- Drastically improved in their ability to pay attention in class and keep up in school activities
- Experienced fewer problems accessing and using health care

A copy of the full report *(Health Status Assessment Report)* is attached to the Annual Report.

Increased Enrollment. Enrollment continued to increase during the reporting period, with over 596,000 enrolled by September 30, 2002. This represents 78.5% of the total number of children eligible for the program based on finding from the CHIS.

Successful Outreach Partners. A recent study of outreach efforts revealed the top producers with respect to assisting applicants in submitting applications. Insurance agents, providers and community based organizations constitute 73 percent of the types of individuals assisting HFP applicants. However, clinics and government programs combined submit almost 50 percent of the applications received among the top 25 enrolled entities from September 2000 through August 2001.

Health plans also provide application assistance. Over half of the plans participating in HFP were trained and approved to provide application assistance. Health plans have assisted with over 6,000 applications. MRMIB has received no reports of misconduct. *(A copy of report is attached)*

Minimal Crowd-Out. According to a study conducted by the University of California, San Francisco, crowd-out is not a problem in the HFP. The study revealed that approximately 8 percent of children enrolled in the program meet the definition of crowd-out (had prior insurance coverage and did not meet any of the exceptions that are allowed). *(A copy of the report is attached.)*

Improvement in Access to Preventive Care. In the two years that health plans have been reporting immunization rates, well-child and well-adolescent visits and access to primary care practitioners, the program has seen marked improvements in the utilization rates reported for these program measures. The scores seen for the program are most similar to NCQA's commercial benchmarks and are higher than national Medicaid results. A copy of the Quality Measurement Report is attached to the Annual Report.

Why Eligible Children Lose or Leave SCHIP – NASHP Study. Seven States, including California, participated in this study. Results showed States may be over-estimating the number of lapsed children who may still be eligible for SCHIP. Parents appreciate SCHIP and lapsed families want to re-enroll their children. Renewal process and premiums are not barriers to retention. A copy of the California report is attached.

LIST OF ATTACHMENTS

TO THE 2002 FEDERAL ANNUAL REPORT

ATTACHMENT 1

Why Eligible Children Lose or Leave SCHIP—NASHP Study

How and Why Eligible Children Lose or Leave SCHIP/Healthy Families

♦ California Graphic Report ♦

NASHP SCHIP SWOT Team
Retention and Disenrollment Study

Conducted for and with The National Academy for State Health Policy
Conducted by Lake Snell Perry & Associates

Background: NASHP SCHIP SWOT Team on Retention and Disenrollment

- NASHP, California and six other states (AL, AZ, GA, IA, NJ, and UT) formed the *NASHP SCHIP SWOT* Team on Retention and Disenrollment* to study why some parents exit SCHIP even though their children are likely still eligible, and why other parents maintain enrollment. Over the past two years the team has worked to develop and test strategies to improve retention and decrease disenrollment of children who remain eligible for SCHIP.
- As part of this effort, NASHP commissioned LSPA to conduct a study exploring these issues from the parents' perspective. LSPA conducted focus groups and a comprehensive telephone survey with parents of current and past SCHIP enrollees.
- This graphic report details the results from California's Healthy Families program, both independently and in comparison to the full seven state results.

* SWOT teams examine **S**trengths, **W**eaknesses, **O**pportunities and **T**hreats in program and policy in a systematic way in order to properly characterize the problem and identify possible solutions.

Definitions and Context: SCHIP Retention, Disenrollment and "Lapsing"

"Disenrollment" is a catch-all phrase that includes all children who exit the SCHIP program. Children's families disenroll, or exit, the SCHIP program in two ways:

1. Becoming ineligible:

Families' changing circumstances make them ineligible for SCHIP under current state and federal rules. Enrollees become ineligible if: family income exceeds eligibility thresholds, child "ages out", family obtains insurance through an employer or switches to Medicaid (Medi-Cal).

2. Lapsing coverage:

Families, either

a) do not complete the annual renewal process, or

b) fall behind in their premium payments.

Children in these families likely remain eligible for SCHIP, but are terminated for non-renewal or non-payment.

More on Lapsing

- These "lapsed families" are of concern because their children are losing SCHIP coverage, despite potentially remaining eligible, and are likely becoming uninsured.
- It is these "lapsed families" that are the focus of the SWOT team project. This project seeks to understand why they lapse and to gain insights into program improvements that would help them remain in the program.
- In this study, attempts to interview lapsed families resulted in a surprising finding: roughly two-thirds of the families identified in states' records as "lapsed" gave different accounts of their child's exit from SCHIP. According to these parents, their children left for different reasons – reasons that likely make them ineligible for the program. This is described in more detail in Section I of this report.

Methodology in Brief I

Two study components:

1) **Six focus groups** conducted Winter 2001, including two in California. In each state (CA, NJ, UT), one with current enrollees and another with lapsed families. In California, the lapsed families group was conducted in Spanish in Fresno. The current enrollees group was conducted in English in LA.*

2) **Seven-state survey** conducted in Summer 2001. 3,780 parents of current and past SCHIP enrollees in seven states. In California: 709 current and past Healthy Families enrollees. Interviewing in English and Spanish.

*All quotes in this report are from California focus groups.

Methodology in Brief II

Both components focused on two groups:

1) **Current enrollees** in Healthy Families/SCHIP who have been enrolled for at least six months
   In California n=416 unless otherwise noted
   In seven-state data n=2,780 unless otherwise noted

2) **Lapsed families** from Healthy Families who were terminated for not completing the annual renewal process or not paying their premium.
   In California n=293 unless otherwise noted
   In seven-state data n=1,000 unless otherwise noted

Organization of Report

The research findings from the focus groups and telephone survey are broken into two sections:

Section I: Who Are the Lapsed Families?

Discusses how state records and parents' perceptions differ around lapsing, and how and why states' records may overestimate the incidence of lapsing. Most of these findings emerge from the survey screening process – that is, the process of determining whether an individual qualified for the survey – and not from the actual questionnaire. These findings have implications for how states define and measure retention rates.

Section II: How SCHIP Works for Families and Why Some Families Lapse

Covers current enrollees' and lapsed families' assessment of SCHIP and how certain programmatic aspects of SCHIP – specifically the renewal process and premiums – may contributing to lapsing. This section talks specifically about how and why lapsed families say they lapsed. These findings point to specific elements of SCHIP that states can address and improve that will likely have a direct impact on retention.

SECTION I:
Who Are the Lapsed Families?

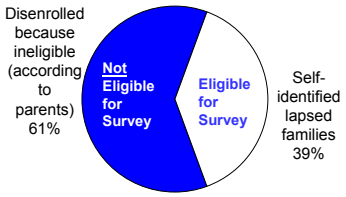
States Likely Overestimating the Incidence of Lapsing

- The reasons parents say their children are no longer enrolled in Healthy Families/SCHIP frequently differ from the reasons program records indicate.
- Many state-identified lapsed families were ineligible for the survey – and may not really be lapsed families.
- In the screening process state-reported, self-confirmed past enrollees were asked why their children were no longer enrolled in Healthy Families:
  - 39% reported renewal, premium, other problems or said they did not know why they were no longer enrolled. This group was eligible for the survey.
  - 61% say their children were no longer enrolled for other reasons – for example, that the family obtained private health insurance or they thought they were no longer eligible due to a change in income. If valid, these reasons would make the child ineligible for Healthy Families. This group was not eligible for the survey.
- In both California and in the full seven state survey it seems lapsing is a smaller problem than might have been expected.

CALIFORNIA

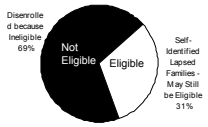
Only about 4 in 10 Healthy Families recorded lapsed families are lapsed according to parents

n=747 Self-Identified Past Enrollees



SEVEN STATE

n= 3,134 Self-Identified Past Enrollees



Sample Depletion: Many state-identified lapsed families were ineligible for the survey – and may not really be lapsed families

The table on the next page shows how the sample of potential lapsed families was depleted during screening:

- Interviewers reached 914 parents who acknowledged having had children enrolled in Healthy Families.
- 167 (18%) of these parents said their children were currently enrolled,
  - Given the time lag between when the sample was drawn and when fielding finished, it is conceivable that some of these families could have exited and reenrolled. Analysis suggested the lag is only partially responsible for the difference between parents' understanding and states' records; 38% had reenrolled in the spring or summer of 2001.
- This left 747 self-identified past program participants.
- Six in 10 (61% or 456) reported that they left for reasons that made them ineligible for participation in the survey, and likely ineligible for Healthy Families.

… continued

Continued:

Sample Depletion: Many state-identified lapsed families were ineligible for the survey – and may not really be lapsed families

- In the end we had 291 lapsed families eligible for the survey. (An additional 2 lapsed families were from the current enrollees sample, giving a total sample of 293 lapsed families.)
- The pattern of sample depletion of the seven state data is similar.

	California			Seven State		
	Raw Number	% of those w/ Program Exp. n=914	% of Self-identified Past Enrollees n=747	Raw Number	% of those w/ Program Exp. n=4,150	% of Self-identified Past Enrollees n=3,134
Potential lapsed family participants say they have program experience	914	-	-	4150	-	-
Say currently enrolled	167	18	-	1016	24	-
Self-identified past enrollees	747	82	-	3134	76	-
Ineligible due to reason they report they left Healthy Families/SCHIP	456	50	61	2177	52	69
Completed self-identified lapsed families from lapsed family sample	291*	32	39	957*	23	31

* Additional lapsed families added from current enrollee samples (CA=2, Seven State=43)

Reason for Leaving among Participants from Lapsed Sample Ineligible for Survey

61% of the past participants reached from the "lapsed families" sample were ineligible for the survey because they said they left for reasons that, if valid, would make them ineligible for Healthy Families. The table on the next page shows the reasons participants gave for their child's exit.

- 233 (51%) said their child got private insurance. This suggests some parents who leave because they obtain private insurance do not report this to the program. Instead, they stop paying their premiums or do not complete their renewal when the time comes.
- 121 (26%) said they are no longer enrolled because a change in income made them ineligible. It is unclear how they came to this conclusion. Are they doing their own eligibility determination?
- 60 (13%) reported that their child moved to Medi-Cal.

… continued

NASHP SCHIP SWOT

Continued:

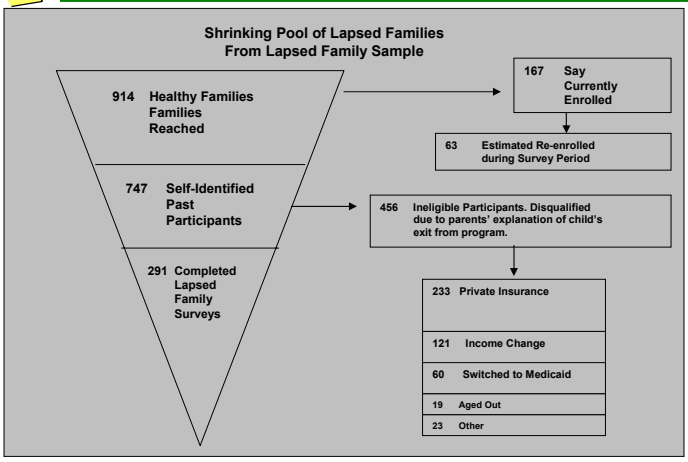
Reason for Leaving SCHIP among Participants from Lapsed Sample Ineligible for Survey

- 19 (4%) said their child was no longer eligible because of age. It is unclear how parents determined that their child was too old for Healthy Families.
- 23 (5%) gave other reasons for their child's exit.
- The pattern of sample depletion of the seven state data is similar.

	California		Seven State	
	Raw Number	% of 456	Raw Number	% of 2,177
Private Insurance	233	51	1179	54
Income Change	121	26	477	22
Switch to Medi-Cal	60	13	268	12
Aged out	19	4	162	7
Other	23	5	91	4

NASHP SCHIP SWOT

Graphic of Sample Depletion



Most Lapsed Families Remain Uninsured

- The fact that there are likely far fewer lapsed families than anticipated is good news. It suggests there are fewer uninsured Healthy Families-eligible children who have fallen off the Healthy Families rolls. However, it is not quite time to declare victory.
- Even if there are fewer lapsed families than expected, they are important. And, the majority – in California (61%) and in other states (62%) – remain uninsured despite probably remaining eligible for Healthy Families/ SCHIP coverage.

	California n=293 %	Seven State n=1,000 %
All Children Uninsured	61	62
All Children Privately Insured	10	13
Mixed Status Family	9	6
All Children on Medicaid	7	5
Status Unclear	13	14

- Moreover, we do not know about the current insurance status or Healthy Families/SCHIP eligibility of the 456 (61%) state-reported, self-confirmed lapsed families who were not eligible for participation in the survey.

SECTION II:

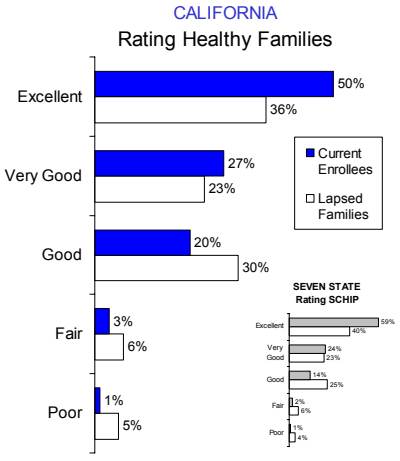
How SCHIP Works for Families and Why Some Families Lapse

PART A:
Positive Views of
Healthy Families/SCHIP

Healthy Families Gets High Marks

- Healthy Families gets high ratings from parents. Three-quarters of current enrollees (77%) give the program a rating of very good or better, including half (50%) who rate it excellent.
- Lapsed families are a little less positive about the program. Still six in ten (59%) rate the program very good or better.
- This patterns echoes findings in the full seven state survey, though Healthy Families ratings are slightly lower.

I am 100% satisfied [with the SCHIP program] because it covers everything. They take very good care of my children.
- Spanish-Speaking Current Enrollee



NASHP SCHIP SWOT

Parents Rate Care and Coverage Highly

- Healthy Families' gets high marks for it's basic medical care. Seven in ten (70%) lapsed families rate the basic care very good or better. Enrollees are even more positive (76%).
- Parents are slightly less positive about Healthy Families' drug coverage and dental care. Still, a majority of enrollees and a near majority of lapsed families rate these aspects very good or better; few give them fair or poor ratings.
  - Some parents do not know enough about dental care to rate the program, suggesting they may not be using these services.
- Aggregate data are similar, but slightly more positive.

	California		Seven State	
	Current Enrollees	Lapsed Families	Current Enrollees	Lapsed Families
Basic Medical Care				
Excellent	50	43	57	46
Very Good	26	27	26	25
Good	19	22	13	21
Fair	4	3	2	3
Poor	*	1	1	1
Dk/Ref	1	3	1	3
Rx Coverage				
Excellent	35	27	52	40
Very Good	25	20	23	20
Good	22	29	14	22
Fair	9	6	4	3
Poor	3	3	1	2
Dk/Ref	6	14	5	12
Dental Care				
Excellent	35	30	43	34
Very Good	23	18	21	16
Good	20	28	15	20
Fair	6	4	5	4
Poor	5	5	4	5
Dk/Ref	11	16	12	21

*= < 0.05%

NASHP SCHIP SWOT

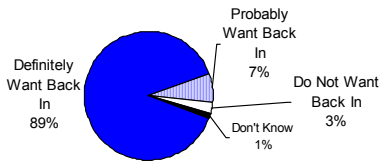
Lapsed Families Want Back In

- An overwhelming majority (96%) of lapsed families say they would like to get their child back into Healthy Families.
- In the full seven state findings too, the strong majority of lapsed families (94%) express interest in reenrolling.

CALIFORNIA

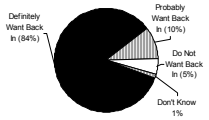
If you could get your child back into Healthy Families today, would you?

n=293 Lapsed Families



SEVEN STATE

n=1,000 Lapsed Families



Parents Appreciate Healthy Families' Low Cost, Care, Coverage, and Access

- When parents with positive assessments of Healthy Families were asked to describe, in their own words, what they like best about it, affordability tops the list. Parents also volunteer that they appreciate the comprehensive coverage, broad access and high quality care. They like that Healthy Families is for working families.
- Enrollees and lapsed families agree having a child in Healthy Families made them feel "safe and secure" and "fortunate."

	California		Seven State	
	Current Enrollees n=402 %	Lapsed Families n=261 %	Current Enrollees n=2684 %	Lapsed Families n=884 %
Affordable/Free/Cheap	58	52	54	54
Comprehensive Coverage/Good Benefits	17	22	19	22
Good Doctors/Good Care	14	15	10	13
Access to Doctors and Specialists/Choice of Providers	12	13	12	12
It's a Program for Working Families	10	10	8	8
Access to Preventive/Emergency Care when Needed	8	3	8	6

Notes: Open-ended. Multiple responses accepted. Asked of those who rated SCHIP good or above. Total exceeds 100% due to multiple responses. Only answers given by over 5% of participants listed.

PART B:
How and Why Families Lapse

Reasons and Circumstances Leading to Lapsing I

- In designing this survey an implicit assumption was that parents who lapse – that is those who are terminated for non-renewal or skipping premium payments – have made a conscious decision to do so, or at the very least are responsible for the circumstances that led to their termination.
- The reality is more complicated; few lapsed parents feel they made an intentional decision to take their child out of SCHIP and some even say the program is at fault.

> They said my payment was late, and then I get a letter saying that it wasn't late, that it was their fault, not my fault. I just don't understand and it is really frustrating. Then you have to pay all this money just to get them back on the program, and then they tell me that they are terminated again.
> - Lapsed Family

Reasons and Circumstances Leading to Lapsing II

The causes of lapsing are complex. Both parents and program play a role. The causes and circumstances underlying lapsing can be divided into two categories*.

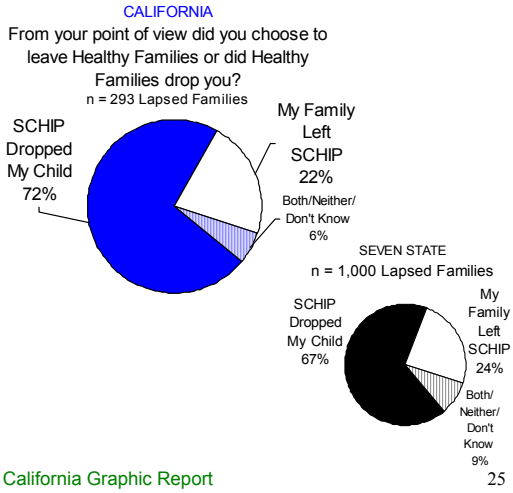
1. Life Situations and Personal Attitudes
   - Fluid financial and personal lives make sustaining enrollment difficult for some.
   - Understanding the events and conditions in these families' lives that can lead to lapsing from SCHIP is vital to helping parents sustain their children's enrollment.
   - Though these factors are less about the SCHIP program per se, there are certain programmatic elements that contribute to these reasons, and programmatic changes that could mitigate them.

2. Misinformation and Mistakes in Process and Program
   - Parents suggest lapsing sometimes has more to do with program inadequacies and errors than with decisions or actions on the part of the parents.
   - Complexity, confusion and miscommunication around renewal and payment can cause parents frustration, and even lead to eligible children being terminated.
   - Some focus group participants make a strong case that their children were incorrectly dropped, despite their efforts to sustain enrollment.

*To some extent this is a false distinction; the circumstances in which any family leaves SCHIP are complex and not easily classified. However this framework is useful in guiding the discussion.

Most Lapsed Families Say They Did Not Mean To Leave Healthy Families

- The majority of lapsed families perceive that – whatever their actions – it was not their intention to leave Healthy Families.
- In the seven-state data two-thirds of parents feel that the SCHIP program dropped them.



Parental Perception and State Records Differ as to Actual Cause of Termination

- The difference between parental perception and state records is more pronounced when parents' answers are compared to what state records list as the causes of termination. Of those lapsed families from the non-payment sample, 69% agree they were terminated for non-payment. 10% are not sure why they were removed from SCHIP. Among state-recorded, non-renewal lapsers just over half (53%) know they were terminated for non-renewal. 16% are not sure why they were removed.
- The California data are similar to the seven state data.

	California			Seven State		
	All Lapsed Families n=293* %	from Non-Payment Sample n=135 %	from Non-Renewal Sample n=156 %	All Lapsed Families n=1000* %	from Non-Payment Sample n=527 %	from Non-Renewal Sample n=430 %
Could not/Did not Pay Premium	39	69	13	41	70	9
Could not/Did not Complete Renewal	31	6	53	29	7	55
Program took you off, not sure why	14	10	18	16	13	23
Admin. glitch/Mistake by program, parent (vol.)	6	4	7	4	2	5
Planned life change (vol.)	3	4	3	3	2	3
Did not want/need Healthy Families/SCHIP	3	3	3	2	2	3
Other (vol.)	4	4	4	5	4	2

* Additional lapsed families added from current enrollee samples (CA=2, Seven State=43)

Renewal and Non-Renewal Lapsed Families

- Healthy Families' renewal process is not a problem for most, but some do find it difficult.
- Some parents do not complete the process, even though they would like to have their child remain enrolled.
- Looking at:
  - Self-identified, non-renewal lapsed families' explanations about why they did not complete renewal
  - Opinions about the renewal process of current enrollees and lapsed families who report they have had experience with renewal

Why Non-Renewal Lapsed Families Say They Did Not Renew

- Lapsed families who reported that they were terminated because they failed to complete renewal process were asked why they did not renew. The most common single response was that they "forgot or did not get around to it." Parents also point to problems with the program. Over four in 10 say they never received their renewal paperwork (15%), did not know they had to renew (14%) or that the program (14%) lost their paperwork.
- Seven state data show similar findings.

	Non-Renewal Lapsed Families	
	California	Seven State
	n=92	n=291
	%	%
Forgot or just did not get around to doing the paperwork/ Incomplete paperwork/Late paperwork	34	35
Never received renewal documents from Healthy Families/SCHIP	15	15
Sent in all the materials, but Healthy Families/SCHIP said you did not send them	14	9
Didn't know you had to renew	14	12
The program wanted background information you couldn't get	10	8
Did not know how to fill put paperwork/paperwork was in English	3	1
You just did not want your child to be in Healthy Families/SCHIP anymore	2	2
(Vol.) Did not think you would qualify anymore/anyway	2	2
(Vol.) You were told your family did not qualify	2	1

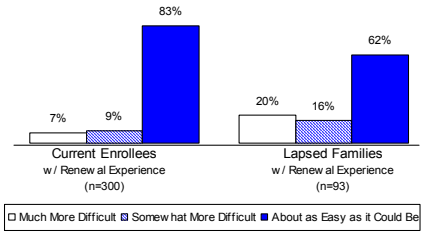
Notes: Only responses given by over 1% reported. Responses marked "Vol." were not part of the list read to participants and were volunteered by participants

Most Parents Say Renewal Is About as Easy as Possible – But Some Find it Onerous

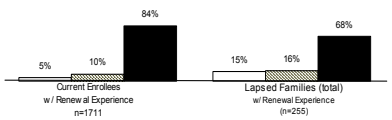
- The majority of current enrollees (83%) and lapsed families (62%) perceive Healthy Families' annual renewal process to be "about as easy as it could be."
- However, over a third (36%) of lapsed families feel the process is somewhat (16%) or much (20%) more difficult than need be.
- The seven state survey showed similar results, though California lapsed families are a little more likely to believe the renewal process is more difficult than necessary (36% vs. 31%)

CALIFORNIA

Is the renewal process much more difficult than it needs to be, somewhat more difficult than it needs to be, or about as easy as it could be?



SEVEN STATE



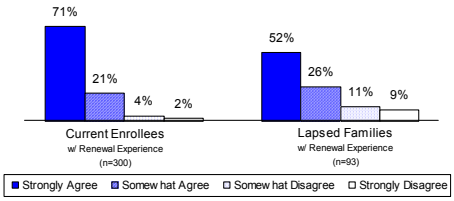
Most Feel Renewal Forms are Simple – But Some Find Them Difficult

- The majority of current enrollees (92%) and lapsed families (78%) agree that "the Healthy Families program has made the renewal forms easy to fill out."
- Lapsed families (18%) are more likely than current enrollees (6%) to feel the forms are forms are complicated.
- The seven-state survey showed similar results.

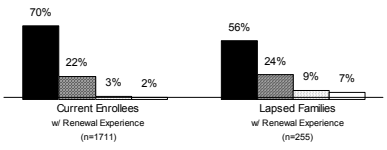
> It is very difficult for someone who has very little schooling to fill out a questionnaire of that kind.
>
> - Spanish-Speaking Current Enrollee

CALIFORNIA

Agree or Disagree: Healthy Families has made its renewal forms easy to fill out?

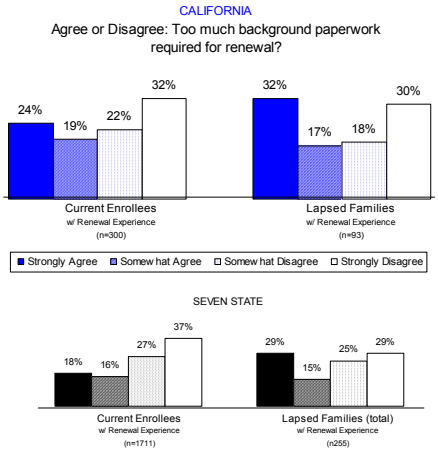


SEVEN STATE



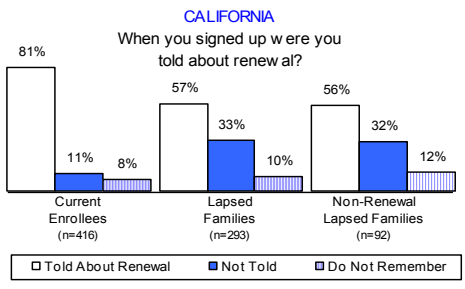
Gathering the Documentation Required for Renewal Is Seen As Burdensome by Some

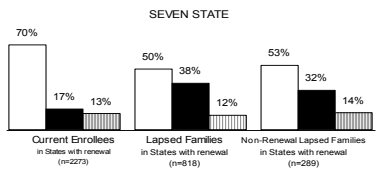
- Over four in ten (43%) current enrollees strongly or somewhat agree that "they ask for too much background paperwork, such as pay stubs or income documentation" in renewal. Lapsed families are even more likely to feel this way (49%).
- Healthy Families current enrollees and lapsed families are more likely to voice complaints about this aspect of renewal than participants from other states' programs, as the comparison with the seven state data shows.
- Focus group results suggest parents in atypical work situations have more trouble than others with income verification requirements.



Many Parents Claim They Were not Told about Renewal

- All parents* were asked whether they were told they needed to renew annually. Most (81%) current enrollees say the were told about renewal. Just over half (57%) the lapsed families say they were told.
- Comparison of these numbers with those from the seven-state survey suggests Healthy Families appears to be doing a slightly better job than some other states in making parents aware of renewal.





*Including those who said they had no renewal experience

I didn't even know that I had to renew. I thought that I would continue paying, that they would know that my son is 11 so he is going to be in it for seven more years…I didn't know that I had to send in more information.

- Lapsed Family

Premiums and Non-Payment Lapsed Families

- Generally, parents who pay a premium feel the amount is reasonable.
- Nevertheless, this study finds that sometimes parents find it hard to pay their premium.
- Looking at:
  - Self-identified, non-payment lapsed families' explanations about why they did not or could not pay.
  - Opinions about premiums of those current enrollees and lapsed families who report they pay premiums.

Why Non-Payment Lapsers Say They Did Not or Could Not Pay

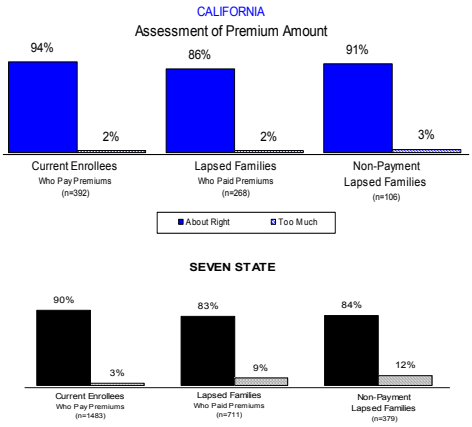
- Lapsed families who reported that they were terminated for non-payment of premium were asked why they did not or could not pay. The most common responses were that they forgot or did not get around to it (39%) and that they did not have the money that month (36%). Some (5%) believe Healthy Families lost their check.
- Healthy Families non-payment lapsed families are about equally divided between those who did not have the money (36%) and those who forgot (39%). In the full seven state survey this group is much more likely to cite lack of funds (56%) than forgetfulness (30%).

	Non-Payment Lapsed Families	
	California	Seven State
	n=115	n=411
	%	%
Forgot or just did not get around to it/Out of country/ Away from Home/Health Problems	39	30
Didn't have the money / Loss of income/ Unemployed	36	56
(Vol.) Payment sent but not received	5	3
Wanted to leave the program	4	2
They changed your premium amount without telling you	2	2

Notes: Only responses given by over 1% reported. Responses marked "Vol." were not part of the list read to participants and were volunteered by participants

Most Say their Premium is Affordable

- Most parents who pay premiums feel they are reasonable. Over nine in 10 enrollees (94%) and almost nine in 10 lapsed families (86%) feel their premium amount was about right. Even the strong majority of non-payment lapsed families (91%) feel the premium was reasonable. Almost none feel premiums are excessive.
- Healthy Families participants are even more likely to feel their fees are reasonable than those in other states.



Parents are Comfortable Contributing to the Cost of their Children's Care

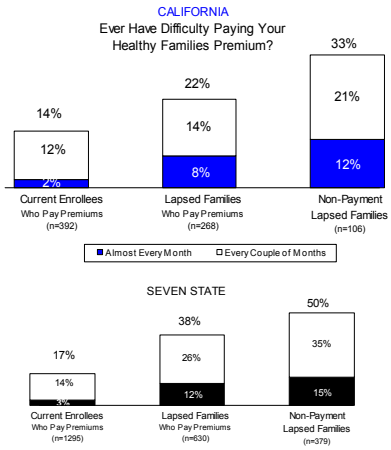
- Parents do not object to paying for their child's Healthy Families coverage. A large majority of enrollees and lapsed families – including non-payment lapsed families – feel paying the premium is "worth it for the peace of mind." Likewise, there is widespread agreement that the care and coverage justify the premium. Majorities agree that they were "happy to pay the premium because I felt better paying part of the cost for my child's healthcare coverage."
- Seven-state data are similar.

	California			Seven State		
	Current Enrollees n=392	Lapsed Families n=268	Non-Payment Lapsed Families n=106	Current Enrollees n=1483	Lapsed Families n=711	Non-Payment Lapsed Families n=379
	% who Strongly Agree					
Premium is worth it for peace of mind	91	88	89	93	86	86
Care and coverage are worth the cost	89	88	87	90	81	81
Happy to pay because I feel better paying part of the cost of my child's coverage	85	88	86	84	83	83

Notes: All are among those who report they pay/paid premiums.

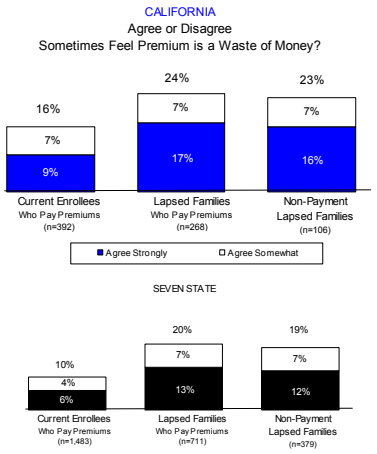
Despite Feeling Premiums are Reasonable, Parents Say Sometimes Paying is Difficult

- 14% of current enrollees say they have trouble paying their premium at least every couple of months.
- Over two in ten lapsed families (22%) and a third (33%) of the non-payment lapsed families say they had trouble paying some months.
- Lapsed families in California are somewhat less likely to say they had difficulty paying on occasion than lapsed families in other states.



A Few Question Whether Paying is Worthwhile

- Though most premium-paying parents do not question the value of paying for insurance, 16% of current enrollees and a quarter (24%) of lapsed families agree that they "sometimes felt paying the premium was a waste of money since their children were healthy and did not need medical care very often."
- Seven state data show a similar pattern.

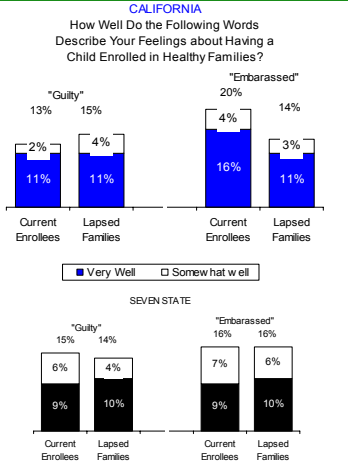


Contributing Factors: Parents

- As we have seen, generally parents – even lapsed families – say the renewal process is fairly easy. Nevertheless, it can cause some parents trouble at some times. Likewise, while most parents consider their premiums affordable, paying can be difficult at times.
- In addition to these areas, this research project investigated other ways in which parents' lifestyles, attitudes or beliefs may affect their willingness and ability to maintain SCHIP enrollment.
- Some of these hypotheses were borne out in the data and others were not.

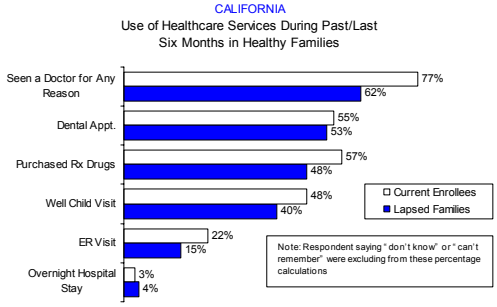
Pride, Stigma, and Guilt Do Not Appear to be Significant Causes of Lapsing

- None of the lapsed families in the survey volunteered that guilt or embarrassment were primary factors in their decision to leave Healthy Families.
- However, a few parents do admit to feeling guilty or embarrassed about having their child in Healthy Families. However, these feelings are no more prevalent among lapsed families than among current enrollees. In fact, enrollee are slightly more likely to say they feel embarrassed.
- Seven state data also show that feelings of guilt and embarrassment are somewhat rare.



Use of Health Services Does Not Appear to Be a Major Factor in Retention or Lapsing

- One hypothesis is that families leave Healthy Families because they are not using its services. These data suggest that this is a factor, but less so than might be expected. Lapsed families were somewhat less likely than enrollees to use some services – like doctor visits and buying prescription drugs – during their last six months in the program.
- It is worth noting that, because the question was asked in terms of the last six months, the results may only imply that lapsed families were less likely to use services in their final months on the program.
- The seven state numbers (not shown here) show a similar pattern.



Survey Does Not Suggest Healthier Children More Likely to Leave Healthy Families

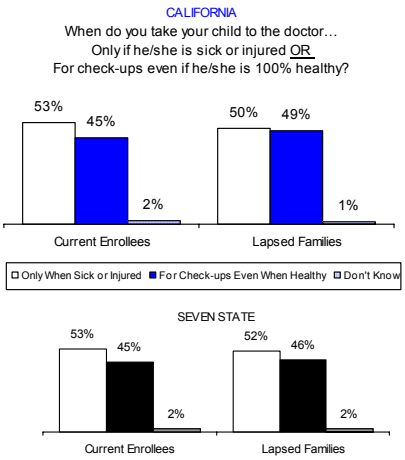
- These data do not support that "healthier" children are more likely to leave Healthy Families. Indeed, the survey suggests lapsed families are "sicker" than enrollees; lapsed families are more likely than enrollees to report that at least one child in their home is in fair or poor health.
- The seven state findings are similar.

	% saying at least one child in household in fair or poor health
California	
Current Enrollees	9
Lapsed Families	17
Seven State	
Current Enrollees	10
Lapsed Families	17

- The meaning of this finding is difficult to interpret. It is unclear if the health status of the lapsed children has deteriorated since leaving SCHIP, or if their poor health pre-dates their leaving SCHIP. It also may be that this finding is actually measuring parents' worry about their lapsed child (most of whom are currently uninsured), instead of the child's true health status. More research is needed to understand this finding.

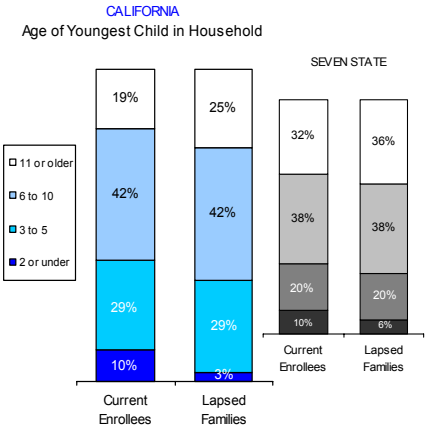
Appreciation of Preventive Care Does Not Appear to be a Factor in Lapsing

- Another hypothesis is that parents who place more value on preventive care would be more likely to sustain their child's Healthy Families enrollment.
- These data do not show such a relationship. In fact, current enrollees are slightly more likely to say "they only take their children to the doctor when they are sick or injured," than that they "take them for check-ups even if they are 100% healthy." Lapsed families are evenly divided between those who only go for injury or illness and those who go for check-ups.
- In the seven state, both current enrollees and lapsed families are slightly more likely to say "they only take their children to the doctor when they are sick or injured."



Parents of Older Children are Slightly More Likely to Lapse

- Another hypothesis is that parents with young children will sustain enrollment while families with older children will lapse.
- In California, enrollees are more likely than lapsed families to have a child age two or under in their household (10% vs. 3%). Conversely, lapsed families are slightly more likely to say their youngest child is 11 or older (25% vs. 19%).
- A similar, but weaker, relationship exists in the seven state data.
- Another interesting comparison with the seven state data: Healthy Families appears to have fewer families – both current and lapsed – in the upper age ranges.



Other Contributing Factors: Program

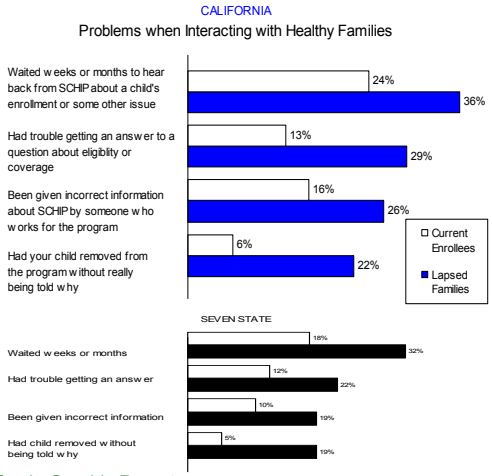
- Some lapsed families feel Healthy Families made it difficult for them to work through problems and sustain enrollment.
- The data suggest several other ways in which programmatic factors may contribute to lapsing. Parents feel the program can do more to help them keep their children enrolled.

> I called them when I first got the letter [about termination] and the person I was talking to didn't seem to understand what I was talking about. They said, 'Well, you have to write a letter and here is the appeals address.' I was like, 'Well, can you tell me what happened? Did you get my check? I sent my check. I have it cancelled.' And they said, 'Oh I don't have that information you have to write an appeal.' That was all they could say. I think he didn't have access to the file. I work as a secretary in an office and we keep a record on all of your accounts. Did he not have access to that? Couldn't he just look at that and tell me something.
>
> - Lapsed Family

> They called and asked me why my children are terminated. And I was thinking - you should know.... I had to cry because it is just so frustrating trying to get through to these people and telling them that they should have that information on your system. I sent in the appeal, and I am sending out another one. They said my payment was late, and then I get a letter saying that it wasn't late, that it was their fault, not my fault. I just don't understand and it is really frustrating. Then you have to pay all this money just to get them back on the program, and then they tell me that they are terminated again.
>
> - Lapsed Family

Lapsed Families Are more Likely than Enrollees to Have Experienced Communication Problems with Healthy Families

- A quarter of enrollees and over a third of lapsed families say they have had long waits to hear back from Healthy Families about enrollment or some other issue. Lapsed families are more likely to have experienced other communication problems as well.
- These communication problems exist in the seven state data as well. However, they do appear to be somewhat more common in Healthy Families.



Healthy Families Staff are Key

- Most parents have found Healthy Families staff helpful and knowledgeable. Lapsed families are a little less positive in their assessment.
- Assessment of Healthy Families staff echo those of other programs' staff.
- Focus group participants say staff who are helpful, polite, and knowledgeable can help families stay enrolled. Those staff who are insensitive, disrespectful, or ill-informed can make sustaining enrollment difficult.
  - Some parents in the focus groups felt that the problem is not with how staff treat them, or how helpful they try to be, but with a lack of knowledge about the program.

> They are polite, and they give you information, but it is not the correct information.
>
> - Lapsed Family

	% found Staff Helpful	% found Staff Knowledgeable
California		
Current Enrollees	92	87
Lapsed Families	85	74
Seven State		
Current Enrollees	94	87
Lapsed Families	83	76

Summary

- Healthy Families, like other states' SCHIP programs, likely over-estimates the incidence of lapsing.
- Parents – including lapsed families – give Healthy Families high ratings. They appreciate the program not only for its low cost, but also for the quality of care and breadth of services.
- The causes of lapsing are complex. Both parents and the program play a role.
  - Few parents make a proactive decision to leave the program, but sometimes their actions (or inactions) lead to their child losing coverage.
  - The program could improve its efforts to retain parents who do want to keep their children in the program.

Implications I

These findings offers ideas for improving SCHIP practices and procedures to help eligible families remain enrolled. Indeed, California and the other states are already making changes based on these findings. Survey findings suggest states should consider the following ideas to improve SCHIP retention:

Follow-up with lapsed families to better understand which families have truly lapsed and which have disenrolled because they are ineligible. Following-up would not only help states track and measure retention, disenrollment and lapsing, but would also help to retain families on the verge lapsing.

Educate families more about the renewal process. Families are not being told about the process often or clearly enough, or are ignoring or misunderstanding the information provided.

Enhance communication pathways between the program and parents. These findings suggest quicker and clearer responses from SCHIP, and fuller explanations to families about why they are experiencing problems, could help families stay enrolled.

Implications II

Provide additional training and support for SCHIP staff. Since SCHIP staff play such a key role in retention, states may want to invest in additional training to enhance staff's ability to troubleshoot and keep eligible families enrolled in the program.

In terms of designing future research, the most important lesson learned is that the circumstances and reasons leading to lapsing are complicated. Specifically, why a family leaves SCHIP and how they affect that exit are sometimes two separate issues. To give what appears to be a common example, parents might decide to leave SCHIP because they have alternative insurance, but they affect this exit by simply discontinuing payment of the family's SCHIP premium.

ATTACHMENT 2

Quality Measurement Report 2001

Quality Measurement Report - 2001

The major quality objective for the Healthy Families Program (HFP) is to "assure that health services purchased for the program are accessible to enrolled children". To meet this objective, the Managed Risk Medical Insurance Board (MRMIB) uses several tools to monitor access and quality of health care. One of these tools is the health plan quality reports that are submitted by participating health plans annually.

The health plan quality reports consist of a selected set of quality indicators. These indicators were selected based on recommendations from the HFP Quality Accountability Framework, (which was commissioned by the California HealthCare Foundation), the HFP Quality Improvement Work Group and the HFP Advisory Panel. The indicators that were selected include a set of child-relevant HEDIS® (Health Plan Employer Data and Information Set) measures applicable to the calendar year 2001 and a measure that was developed by the California Department of Health Services for the Medi-Cal Managed Care Program.

This report, the Healthy Families Program Quality Measurement Report 2001, summarizes the reports received from participating health plans. Results from individual health plan reports provide trends of health care quality for the HFP. In addition, this report creates a foundation for comparing year-to-year plan performance and for comparing the HFP to other programs (e.g., Medicaid and commercial programs).

QUALITY INDICATORS

HEDIS®

The National Committee for Quality Assurance's (NCQA) HEDIS® is a nationally recognized tool to evaluate services provided by health plans. Public and private organizations that purchase health care services are principal users of HEDIS®. Many purchasers of health insurance use HEDIS® as a standard of quality measurement.

HEDIS® consists of 56 measures across eight categories or *domains.* For the HFP, participating health plans were required to report five child-relevant measures across three domains. Descriptions of the domains and the related measures are described below.

Domain	Measure
Effectiveness of Care	Childhood Immunization Status
	Follow-up After Hospitalization for Mental Health
Use of Services	Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life
	Adolescent Well-Care Visits
Access/Availability	Children's Access to Primary Care Practitioners

Effectiveness of Care Domain

Effectiveness of Care measures examine the clinical quality of the care delivered within the plan from a variety of perspectives.

The childhood immunization measure within this domain examines how well health plans deliver specific or targeted preventative services to their members, therefore keeping them healthy. The Follow-up After Hospitalization for Mental Illness measure analyzes the use of current procedures and treatments offered to help members recover from illness.

Use of Services Domain
These measures provide information on how plans are providing access to care. They express the percentage of members who were continuously enrolled in the plan for a specified period of time and received defined services.

Access/Availability Domain
Measures in this domain examine how members access basic services provided by their plan. Access refers to the ability of members to get services they require.

120-Day Initial Health Assessment
This measure was developed as a pilot measure by the California Department of Health Services and was tested by health plans that volunteered to participate in the pilot. The measure uses data collection protocols similar to the protocols for HEDIS®. MRMIB adopted the 120-Day Initial Health Assessment to measure the number of newly enrolled children in the HFP who visited a primary care provider within the first 120 days of their enrollment.

REPORTING METHODOLOGY
Data Collection
NCQA gives health plans two options for collecting data for reporting quality. The *administrative method* requires plans to search selected administrative databases (e.g., enrollment, claims, and encounter data systems) for evidence of a service.

The *hybrid method*, requires plans to select a random sample of 411 eligible members, and search their administrative databases for information about whether each individual in the sample received a service. If no information is found, plans are allowed to consult medical records for evidence that services were provided.

Of the measures allowing either data collection option (Childhood Immunizations / Well Child Visits / Adolescent Well Visits), the majority of plans utilized the *hybrid method*. The Access to PCP and the 120 Day Initial Health Assessment measures require the exclusive use of the *administrative method*.

This report uses an *aggregate program score* to show overall program performance for each selected quality measure. The *aggregate program score* is calculated by dividing the sample population of members from *all* health plans who received a particular service by the sample population of members in *all* health plans that were eligible to receive the service.

A detailed analysis was conducted to determine what affect, if any, the combining of the *hybrid* and *administrative* methodologies might have on overall program performance.

The analysis showed that combining the *administrative* and *hybrid* methodologies produced minor adjustments to the aggregate program scores. These adjustments are shown in the following table.

Reported Measure	# of Plans Using Method A= Admin H= Hybrid	Aggregate Program Score	Aggregate Program Score (Adjusted)
Childhood Immunization (Combo 2) (Combo 1)	 H = 22 A = 1	 61.7% 65.1%	 61.3% 64.7%
Well Child Visits	H = 22 A = 1	61.7%	59.6%
Well Adolescent Visits	H = 22 A = 1	32.2%	32.7%
Follow-up Mental Illness 7 Day 30 Day	H = 22 A = 1	27.0% 46.0%	27.0% 46.0%

The HEDIS® Compliance Audit
MRMIB requires all quality data to be audited by an NCQA certified HEDIS® auditor before submitting data to MRMIB. All plans included in this report have complied with the HEDIS® audit requirement.

The HEDIS® Compliance Audit is a two-part assessment consisting of an information systems capabilities assessment, which is followed by an evaluation of the managed care organization's ability to comply with HEDIS specifications.

Audit standards are applied in systematic ways. If there are unanswered questions on the process for collecting the data or for calculating the HEDIS® results, the auditor will recommend not reporting the measure in question. The HEDIS® Compliance Audit ensures the credibility of reported data.

Data Submission
All plans were required to supply MRMIB with the following:

√ Summary of scores for each required measure identifying the eligible population, the methodology used and the score for each measure.

√ An Audit Report certifying that the plan used standard HEDIS® methodologies in the extraction of data used to develop scores for each measure. The audit report is prepared by an NCQA certified auditor who is contracted or employed by a NCQA licensed audit firm.

√ Demographic information for each record that was included in the measure.

Data Analysis
Quality Scores
The individual plan scores or *rates* for HEDIS® measures were developed according to HEDIS® reporting guidelines.

Health plan scores for the 120-Day Initial Health Assessment were developed according to the Department of Health Services specifications.

Rates are calculated by dividing the number of health plan subscribers who received a particular service (numerator) by the number of subscribers who were eligible to receive the service (denominator).

Benchmarking
Benchmarking allows MRMIB to compare plan quality performance with the results of other large purchasers.

The HFP calendar year 2001 results presented in this report are compared with currently available data from the *NCQA National Results* and the HFP results from calendar year 2000. MRMIB chose to use these measures because the results were developed using similar criteria and calculations for each measure.

Standardized measures like HEDIS® employ statistical principles which assume relative stability of the population being evaluated.

Organization of Reported Data
This report presents aggregate program-wide and individual plan scores, for calendar year 2001, for the following measures:

- Childhood Immunization Status
- Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life
- Adolescent Well-Care Visits
- Children's Access to Primary Care Practitioners
- Follow-up After Hospitalization for Mental Illness
- 120-Day Initial Health Assessment

A detailed view of each measure is presented including the following:

- Description of Measure
- Population Statistics
- Benchmark Comparison
- Individual Health Plan Scores
- Results by Selected Demographic Variables

Description of Measure

Definitions for the HEDIS® measures are from the HEDIS® 2002 Technical Specifications manual.

Population Statistics

This section describes the number of plans reporting, total number of members in the eligible population sample, range of scores, *average/median plan score* and *aggregate program score.*

It is important to draw a distinction between the *average plan score* and *aggregate program score*. The *average plan score* is an average of the individual reported scores. The *aggregate program score* is calculated by dividing members from all health plans who received a particular service by the total number of members in all health plans that were eligible to receive the service.

Benchmark Comparison

This report uses current benchmarks from the NCQA *National Results for Selected HEDIS®* measures, and HFP aggregate program scores from the calendar year 2000 HFP data submission.

Plan Score Comparison

A comparison of individual health plan scores is presented for calendar year 2001. All plan scores are presented in tables sorted alphabetically by plan name. The graph of the plan's 2001 score is displayed, along with their 2000 score.

NCQA recommends that scores based on sample sizes of less than 30 should not be reported because they are statistically insignificant.. Due to the limited membership of some plans, there are some measures that did not meet the 30 sample size minimum. Those plans are identified with a "NM" or Not Meaningful.

Demographics

Each measure is presented in tabular form displaying the score for each category along with the sample size (in parentheses). Ethnicity, language and geographical region are presented. The demographic characteristic of subscribers varies by plan.

Ethnicity scores are reported for five ethnic categories (Latino, White, Asian/Pacific Islander, African American and Native American/Alaska Native) as indicated on the child's application.

Language scores are grouped by the language preference of the family as indicated on the child's application. These include English, Spanish, Vietnamese, Korean, and Chinese.

Geographic scores are profiled identifying aggregate scores for each of the six HFP regions. These regions represent Los Angeles, San Diego, San Francisco/Bay Area, Central Valley and rural counties. Counties included in each region are presented in Appendix A.

The HFP tracks multiple ethnic and language categories, but is presenting only selected categories within this report. In addition, many subscribers choose not to supply this demographic information to the HFP during the application process. With this in mind, the sum of the demographic sample populations may not be equal to total eligible population sampled.

Healthy Families Program
Quality Measurement Report Overview

The following summary represents the HFP aggregate program scores for the 1999 through 2001 calendar year periods. For comparison, results from NCQA's National Results for Selected HEDIS/CAHPS® Measures and National Medicaid Results for Selected HEDIS® and HEDIS/CAHPS® Measures for *calendar year 2000 are presented*. NCQA calendar year 2001 results *were not* available at time of publication. Current NCQA results can be obtained from the NCQA website at www.ncqa.org.

Measure Description	Healthy Families Program Score 1999 Calendar Year	Healthy Families Program Score 2000 Calendar Year	Healthy Families Program Score 2001 Calendar Year	NCQA National Average Commercial Results 2000 Calendar Year	NCQA National Average Medicaid Results 2000 Calendar Year
Childhood Immunization Status					
Combination 1*	56%	61%	65%	67%	56%
Combination 2*	48%	57%	61%	53%	47%
Well Child Visits in the 3rd through 6th Years of Life	54%	57%	60%	54%	50%
Adolescent Well-Care Visits	34%	28%	33%	31%	30%
Children's Access to Primary Care Practitioners					
Cohort 1 (ages 12 - 24 months)	88%	87%	89%	92%	88%
Cohort 2(ages 25 month - 6 years)	77%	75%	80%	82%	75%
Cohort 3 (ages 7 - 11 years)	78%	74%	80%	84%	76%
Follow-up After Hospitalization for Mental Illness (1)					
within 7 Days	33%	21%	27%	48%	32%
within 30 Days	55%	34%	46%	71%	53%
120-Day Initial Health Assessment	37%	43%	46%	Not Available	Not Available

* Combination 1 includes age appropriate vaccinations for diphtheria/tetanus/pertussis, polio, measles/ mumps/rubella, H. influenzae type B, and Hepatitis B. Combination 2 includes all age appropriate vaccinations in Combination 1 and the chicken pox vaccine.

(1) Total sample size for this measure was 225 subscribers in 2001 and 112 subscribers in 2000. A factor that may make tracking data difficult for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment.

Childhood Immunization Status

Importance of Measure: It is estimated that one million children in the United States do not receive the necessary vaccinations by age two. Immunizations have proven to be one of the easiest and most effective methods of delivering preventative medicine. Immunizations are the first and foremost line of defense against childhood diseases.

Calculation: This measure is the percentage of children who turned two years old during the measurement year, who were continuously enrolled for 12 months preceding their second birthday and received the following immunizations according to the American Academy of Pediatrics established schedule.

Combination 1
4 DTP/DTaP (diphtheria/tetanus/pertussis)
3 IPV/OPV (polio)
1 MMR (measles/mumps/rubella)
2 HiB (H. influenzae type b)
3 Hep (Hepatitis B)

Combination 2
Same as Combination 1 plus
1 VZV (Chicken Pox)

Based on the above age and timing criteria, a child may have actually received his or her required immunizations but failed to be included in the measure's numerator.

2001 Performance: Childhood immunizations have improved consistently over the last three years. Immunizations based on the Combination 2 measure have grown from 48 percent in 1999 to 57 percent in 2000 to the current rate of 63 percent for 2001. In addition to higher values for the combination rates, scores for the individual antigens have also continued to improve in all categories. Compared to the NCQA national averages, the HFP continues to perform at levels above both commercial and Medicaid benchmarks.

Of the 16 plans that had sufficient data to report for the 2000 and 2001 reporting period, twelve (12) plan scores improved at least one percentage point, three (3) plan scores declined, and one plan score did not change from the prior year *(NCQA requires a minimum of 30 observations to consider the sample valid. Six (6) plans did not meet this minimum and are identified in the following table as NM or not meaningful)*.

The analysis of selected demographics on the following page suggests that the Asian/Pacific Islander population (Asian/Pacific Islander ethnicities, Chinese, Vietnamese, Korean languages) were immunized at a rate higher than other groups.

Performance Overview

Childhood Immunization Status

HFP Population Statistics	1999	2000	2001
Number of Plans Reporting	23	24	23
Total Sample	571	2,586	3,943
Number of Plans Reporting - Methodology	Admin - 1 Hybrid - 22	Admin - 2 Hybrid - 22	Admin - 1 Hybrid - 22
Range of Scores	17% to 72%	34% to 75%	35% to 83%
Average / Median Score	50% / 48%	54 % / 53%	60% / 62%
Aggregate Program Score (Combination 2)	**48%**	**57%**	**61%**

Calendar Year	**Combo 2**	Combo 1	DPT	IPV	MMR	HIB	HEP	VZV
2001	**61%**	65%	78%	83%	88%	79%	79%	83%
2000	**57%**	61%	75%	78%	83%	75%	72%	77%
1999	**48%**	56%	70%	75%	73%	69%	70%	62%

Results by Selected Demographic Variables

Childhood Immunization Status – Combination 2					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino(1,920)	59%	English(1,437)	58%	1(201)	59%
Asian/Pacific Islander (335)	72%	Spanish(1,393)	61%	2(516)	63%
White (421)	58%	Vietnamese (71)	76%	3(360)	60%
African American(56)	54%	Chinese(125)	66%	4(528)	66%
American Indian/Alaska Native(9)	33%	Korean(50)	80%	5(898)	55%
				6(678)	61%

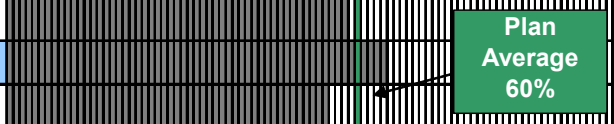
(Number in parentheses indicate the number of children in the eligible sample)

* See Appendix A for definition of regions.

Individual Plan Scores

Childhood Immunization Status – Combination 2

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score *	57%	61%	
Alameda Alliance for Health	NM	63%	
Blue Cross - EPO	53%	59%	
Blue Cross - HMO	63%	63%	
Blue Shield - HMO	46%	55%	
CalOptima	48%	76%	
Central Coast Alliance for Health	NM	NM	
Community Health Group	61%	72%	
Community Health Plan	56%	35%	
Contra Costa Health Plan	NM	NM	
Health Net of California	49%	56%	
Health Plan of San Joaquin	56%	57%	
Health Plan of San Mateo	NM	NM	
Inland Empire Health Plan	50%	73%	
Kaiser Permanente	75%	71%	
Kern Family Health Care	50%	66%	
L.A. Care Health Plan	NM	49%	
Molina	34%	44%	
Santa Barbara Regional Health	NM	NM	
Santa Clara Family Health Plan	60%	67%	
San Francisco Health Plan	57%	78%	
Sharp Health Plan	39%	54%	
UHP Healthcare	NM	61%	
Universal Care	69%	61%	
Ventura County Health Care	NM	NM	
			0 10 20 30 40 50 60 70 80 90 100



NM – Not meaningful. Sample size is too small to draw general conclusions.

* Many plans have low sample sizes for calendar year 2000. Please note when comparing changes in individual plan performance.

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

Importance of Measure: The American Academy of Pediatrics (AAP) recommends annual well-child visits for two to six year olds. Benefits of this measure are detection of potential vision, speech, learning, or other problems that may be prevented by early intervention.

Calculation: This measure describes the percentage of members who were three, four, five, or six years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received one or more well-child visit(s) with a primary care provider during the measurement year.

2001 Performance: The tables on pages 10 and 11 describe trends in performance on an aggregate program view as well as individual plan level.

The overall HFP scores have continued to improve over the past three years, increasing by 3 percentage points per year from the 1999 start date (1999 = 48%, 2000 = 51%, 2001 = 54%). The HFP performance mirrored the improvements in quality demonstrated by the NCQA national commercial and Medicaid averages, which also improved during the 1999-2001 period.

Based on 2001 and 2000 results, the major trends within the demographic analysis are presented in the language of applicant and regional categories, with Korean speakers significantly below the average in both years. Region 3 (Bay Area) was well above the average. The higher regional score is also confirmed by the high relative scores of the three Bay Area health plans (Alameda Alliance for Health San Francisco Health Plan and Santa Clara Family Health Plan).

Individual health plan scoring improved steadily with 18 of the 24 plans (75%) improving by at least 1 percentage point, while 12 plans (50%) improved by at least 5 percentage points. Plans that serve the majority of the HFP subscribers, (Blue Cross, Health Net, Kaiser, Blue Shield) all showed improvement.

Performance Overview

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life

HFP Population Statistics	1999	2000	2001
Number of Plans Reporting	24	24	24
Total Eligible Population	11,023	12,330	14,695
Number of Plans Reporting - Methodology	Admin - 6 Hybrid - 18	Admin - 4 Hybrid - 20	Admin - 3 Hybrid - 21
Range of Scores	29 % to 81%	38% to 84%	40% to 74%
Average / Median Score	56% / 54%	57% / 58%	61% / 63%
Aggregate Program Score	**54%**	**57%**	**60%**

Results by Selected Demographic Variables

Well Child Visits in the Third, Fourth, Fifth and Sixth Years of Life					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (6,810)	62%	English (3,585)	59%	1 (323)	57%
Asian/Pacific Islander (954)	63%	Spanish (5,380)	62%	2 (1,997)	62%
White (966)	54%	Vietnamese (152)	62%	3 (1,879)	68%
African American (199)	57%	Chinese (390)	64%	4 (1,802)	62%
American Indian/Alaska Native (19)	58%	Korean (125)	50%	5 (2,196)	51%
				6 (1,993)	64%

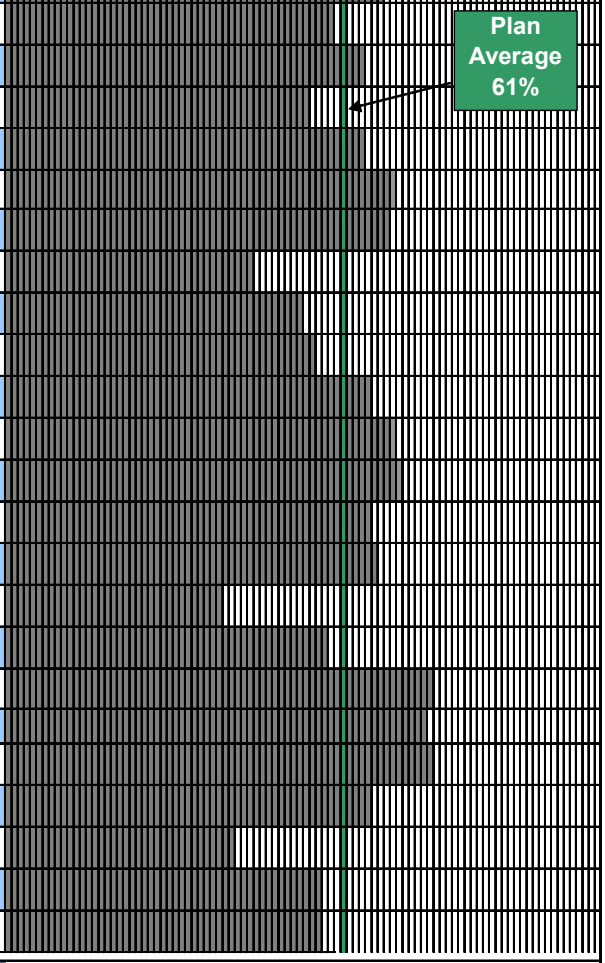
(Number in parentheses indicate the number of children in the eligible sample)

* See Appendix A for definition of regions.

Individual Plan Scores

Well Child Visits in the 3rd, 4th, 5th and 6th Years of Life

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	57%	60%	
Alameda Alliance for Health	61%	67%	
Blue Cross - EPO	56%	58%	
Blue Cross - HMO	63%	63%	
Blue Shield - HMO	45%	53%	
CalOptima	58%	63%	
Central Coast Alliance for Health	70%	69%	
Community Health Group	66%	68%	
Community Health Plan	40%	43%	
Contra Costa Health Plan	56%	52%	
Health Net of California	49%	54%	
Health Plan of San Joaquin	58%	65%	
Health Plan of San Mateo	44%	69%	
Inland Empire Health Plan	58%	70%	
Kaiser Permanente	59%	64%	
Kern Family Health Care	55%	66%	
L.A. Care Health Plan	38%	39%	
Molina	39%	58%	
Santa Barbara Regional Health	61%	74%	
Santa Clara Family Health Plan	72%	73%	
San Francisco Health Plan	84%	74%	
Sharp Health Plan	62%	63%	
UHP Healthcare	62%	40%	
Universal Care	65%	57%	
Ventura County Health Care	49%	57%	
			0 10 20 30 40 50 60 70 80 90 100



Adolescent Well-Care Visits

Importance of Measure: Detection of changes in physical, social and emotional health status during this transitional period in a child's life is of great importance. The American Medical Association and the American Academy of Pediatrics stress the need for yearly visits in this population.

Calculation: This measure describes the percentage of members, ages 12 through 21 years old during the measurement year, who were continuously enrolled in the plan during the measurement year, and who received at least one comprehensive well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year. Because the HFP only covers children through their 19th birthday, the reports from the plans were based on children between the ages of 12 and 19.

2001 Performance: The aggregate program score improved by 5 percentage points to 33 percent. This score is in line with the NCQA national average for commercial and Medicaid plans. Although the aggregate score is a significant improvement, the overall performance picture is mixed, with significant improvements by some of the larger commercial plans being offset by shortfalls in the County Organized Health Systems and Local Initiatives. Of the 24 plans reporting, 14 scores improved, 8 scores declined and 1 remained unchanged.

The table on page 13 titled "HFP Performance Statistics" shows a decrease in the total sample even though the HFP has grown significantly during the 2000 to 2001 period. This decrease is due to a larger number of plans employing the *hybrid method* of data collection. As described on page 2 of this report, this method allows plans to use a random sampling method for scoring. Unless plans have comprehensive administrative data systems, rates based on the *hybrid method* are generally higher, but require more effort and are more costly than the *administrative* method.

There are no significant changes in the demographic performance, with most categories performing at the same relative levels as the previous year.

Performance Overview
Adolescent Well-Care Visits

HFP Population Statistics	1999	2000	2001
Number of Plans Reporting	24	24	24
Total Sample	15,627	33,011	17,841
Number of Plans Reporting - Methodology	Admin - 5 Hybrid - 19	Admin - 6 Hybrid - 18	Admin - 3 Hybrid - 21
Range of Scores	11% to 55%	13% to 47%	16% to 53%
Average / Median Score	34% / 35%	29% / 29%	32% / 33%
Aggregate Program Score	**34%**	**28%**	**33%**

Results by Selected Demographic Variables

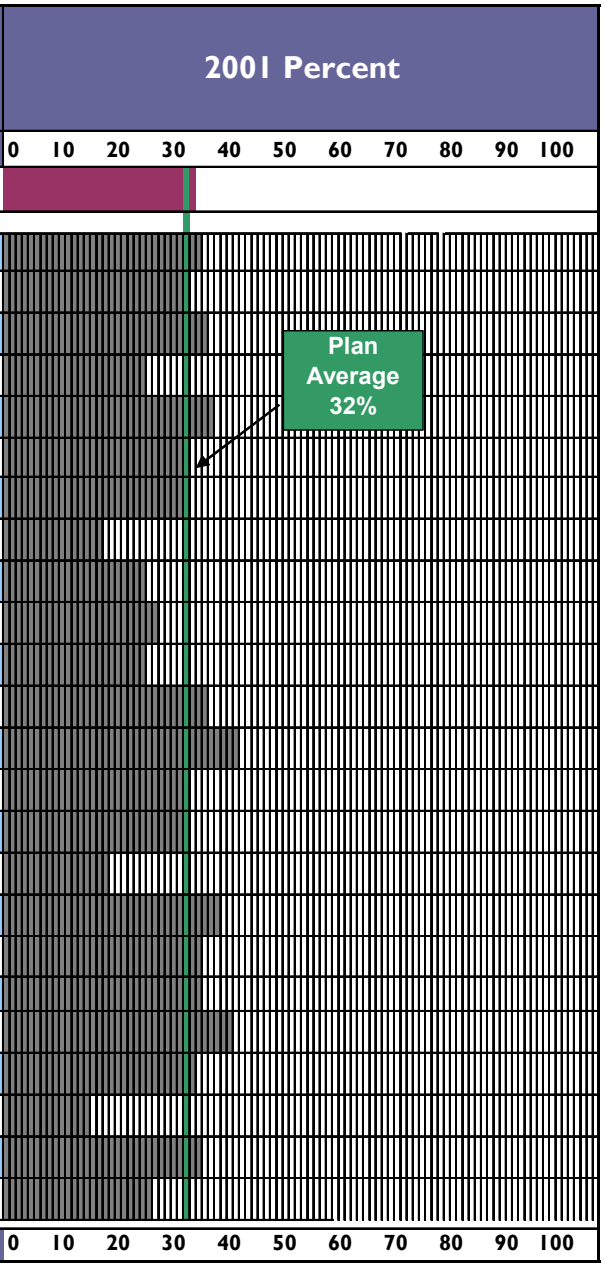
Adolescent Well-Care Visits					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (6,815)	31%	English(4,623)	30%	1(390)	27%
Asian/Pacific Islander (1,521)	34%	Spanish(5,335)	31%	2(2,429)	28%
White (1,480)	30%	Vietnamese (255)	35%	3(2,120)	35%
African American(402)	33%	Chinese (734)	38%	4(1,023)	35%
American Indian/Alaska Native(43)	30%	Korean (575)	31%	5(2,730)	27%
				6(2,559)	32%

(Number in parentheses indicate the number of children in the eligible sample)
* See Appendix A for definition of regions

Individual Plan Scores

Adolescent Well-Care Visits

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	27%	33%	
Alameda Alliance for Health	30%	34%	
Blue Cross - EPO	25%	31%	
Blue Cross - HMO	27%	35%	
Blue Shield - HMO	23%	24%	
CalOptima	31%	38%	
Central Coast Alliance for Health	16%	32%	
Community Health Group	38%	32%	
Community Health Plan	20%	18%	
Contra Costa Health Plan	28%	24%	
Health Net of California	25%	27%	
Health Plan of San Joaquin	28%	24%	
Health Plan of San Mateo	26%	35%	
Inland Empire Health Plan	41%	41%	
Kaiser Permanente	31%	32%	
Kern Family Health Care	34%	32%	
L.A. Care Health Plan	13%	19%	
Molina	29%	39%	
Santa Barbara Regional Health	40%	36%	
Santa Clara Family Health Plan	45%	36%	
San Francisco Health Plan	47%	40%	
Sharp Health Plan	29%	34%	
UHP Healthcare	22%	16%	
Universal Care	33%	35%	
Ventura County Health Care	19%	27%	
			0 10 20 30 40 50 60 70 80 90 100



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Children's Access to Primary Care Practitioners

Importance of Measure: Childhood access to primary care practitioners is positively associated with successful completion of recommended immunizations and identification and treatment of childhood conditions at early stages of disease.

Calculation: This measure describes children in three different age groups who had a visit with a plan primary care practitioner.

Children age 12 months through 24 months who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

In the Healthy Families Program, children in this age range constitute a small portion of the program's total enrollment. This is because children in this age range are only eligible if they are in families with incomes between 200% and 250% of Federal income guidelines.

Children age 25 months through 6 years who were continuously enrolled during the measurement year and had a visit with a primary care practitioner during the measurement year.

Children age 7 years through 11 years who were continuously enrolled during the measurement and the calendar year preceding the measurement year who had a visit year with a primary care practitioner during the measurement year or the year preceding the measurement year.

Children are allowed one gap of up to 45 days during each year of continuous enrollment.

2001 Performance: This Access/Availability measure showed significant improvement during the 2001 reporting period. The overall aggregate program scores for Cohort 2 (25 moths to 6 years) and Cohort 3 (Age 7 to 11 years) improved by at least 5 percentage points. Cohort 1 (Ages 12 to 24 months) improved slightly (2000 = 87%, 2001 = 89%) but represents a very low sample of HFP subscribers.

Almost 90% of plans improved their performance in the Cohort 2 measure for 2001, with Alameda Alliance for Health, Inland Empire Health Plan and Health Plan of San Mateo registering improvements of over 20 percentage points from the 2000 period. Over 50 percent (13 plans), improved their scores by at least 5 percentage points.

Demographic performance for all three Cohorts indicate that Region 5 (Los Angeles) scores are significantly below average, but have shown improvement from levels generated in 2000.

Performance Overview

Children's Access to Primary Care Practitioners
Cohort 1 - Ages 12 to 24 months

HFP Population Statistics *Cohort 1 Age 12 to 24 months*	1999	2000	2001
Number of Plans Reporting	19	23	23
Total Sample	490	1,500	5,222
Number of Plans Reporting - Methodology	Admin - 24 Hybrid - 0	Admin– 23 Hybrid - 0	Admin – 23 Hybrid - 0
Range of Scores	Insufficient data	56% to 98%	72% to 100%
Average / Median Score	Insufficient data	82% / 84%	89% / 93%
Aggregate Program Score	**88%**	**87%**	**89%**

Results by Selected Demographic Variables

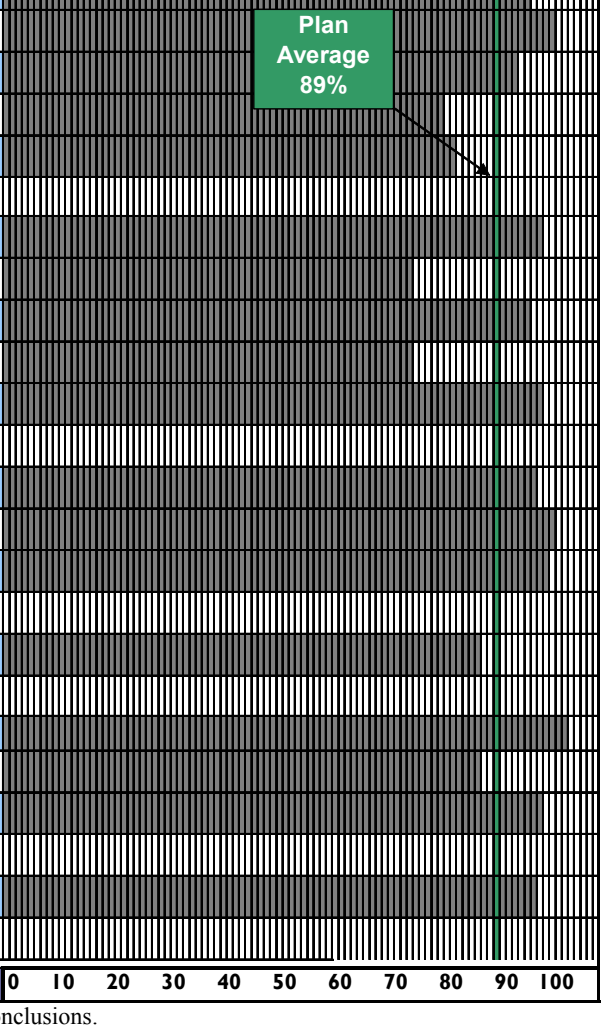
Children's Access to Primary Care Practitioners – Cohort 1					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (2,495)	88%	English(2,329)	89%	1(317)	97%
Asian/Pacific Islander(645)	81%	Spanish (1,607)	88%	2(538)	93%
White (610)	92%	Vietnamese (131)	79%	3(436)	93%
African American(98)	87%	Chinese(158)	79%	4(595)	87%
American Indian / Alaskan Native(8)	88%	Korean(112)	90%	5(1,432)	80%
				6(1,278)	91%

(Number in parentheses indicate the number of children in the eligible sample)
* See Appendix A for definition of regions

Individual Plan Scores

Children's Access to Primary Care Practitioners - Cohort 1
Ages 12 to 24 months

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	87%	89%	
Alameda Alliance for Health	NM	93%	
Blue Cross - EPO	98%	99%	
Blue Cross - HMO	90%	91%	
Blue Shield - HMO	72%	78%	
CalOptima	84%	80%	
Central Coast Alliance for Health	NM	NM	
Community Health Group	77%	95%	
Community Health Plan	56%	72%	
Contra Costa Health Plan	NM	93%	
Health Net of California	66%	72%	
Health Plan of San Joaquin	NM	97%	
Health Plan of San Mateo	NM	NM	
Inland Empire Health Plan	80%	95%	
Kaiser Permanente	99%	99%	
Kern Family Health Care	NM	97%	
L.A. Care Health Plan	NM	NR	
Molina	NM	84%	
Santa Barbara Regional Health	NM	NM	
Santa Clara Family Health Plan	NM	100%	
San Francisco Health Plan	NM	83%	
Sharp Health Plan	89%	93%	
UHP Healthcare	NM	NM	
Universal Care	NM	92%	
Ventura County Health Care	NM	NM	
			0 10 20 30 40 50 60 70 80 90 100



NM – Not meaningful. Sample size is too small to draw general conclusions.
NR– Not Reportable – Audited Results Incomplete.

Performance Overview

Children's Access to Primary Care Practitioners Cohort 2
Ages 25 months through 6 years

HFP Population Statistics – *Cohort 2 Age 25 months to 6 years*	1999	2000	2001
Number of Plans Reporting	24	24	23
Total Sample	14,762	41,608	72,667
Number of Plans Reporting - Methodology	Admin - 24 Hybrid - 0	Admin- 23 Hybrid - 0	Admin - 23 Hybrid - 0
Range of Scores	Insufficient data	25% to 92%	41% to 92%
Average / Median Score	Insufficient data	71% / 72%	80% / 85%
Aggregate Average Program Score	**77%**	**75%**	**80%**

Results by Selected Demographic Variables

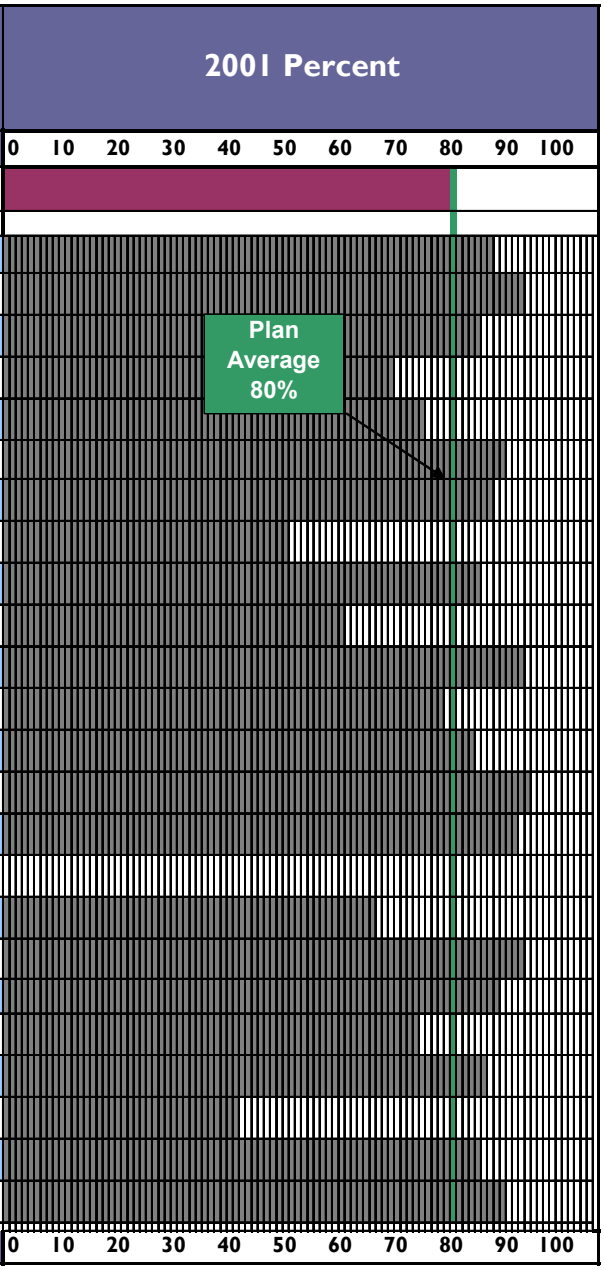
Children's Access to Primary Care Practitioners – Cohort 2					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (40,316)	79%	English(27,364)	80%	1(6,189)	89%
Asian/ Pacific Islander(5,756)	76%	Spanish (30,344)	79%	2(9,381)	86%
White (5,354)	82%	Vietnamese (986)	75%	3(5,608)	84%
African American(1,149)	77%	Chinese(3,170)	74%	4(10,331)	80%
American Indian /Alaskan Native(213)	79%	Korean(1,277)	79%	5(14,458)	67%
				6(14,208)	85%

(Number in parentheses indicate the number of children in the eligible sample)
* See Appendix A for definition of regions

Individual Plan Scores

Children's Access to Primary Care Practitioners Cohort 2
Ages 25 months through 6 years

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	75%	80%	
Alameda Alliance for Health	64%	86%	
Blue Cross - EPO	91%	92%	
Blue Cross - HMO	84%	84%	
Blue Shield - HMO	63%	70%	
CalOptima	68%	74%	
Central Coast Alliance for Health	92%	90%	
Community Health Group	81%	88%	
Community Health Plan	41%	50%	
Contra Costa Health Plan	85%	84%	
Health Net of California	51%	60%	
Health Plan of San Joaquin	88%	92%	
Health Plan of San Mateo	58%	78%	
Inland Empire Health Plan	51%	83%	
Kaiser Permanente	92%	94%	
Kern Family Health Care	86%	91%	
L.A. Care Health Plan	NM	NR	
Molina	50%	64%	
Santa Barbara Regional Health	90%	93%	
Santa Clara Family Health Plan	82%	89%	
San Francisco Health Plan	86%	74%	
Sharp Health Plan	84%	86%	
UHP Healthcare	25%	41%	
Universal Care	83%	85%	
Ventura County Health Care	88%	89%	
			0 10 20 30 40 50 60 70 80 90 100



NM – Not meaningful. Sample size is too small to draw general conclusions.
NR– Not Reportable – Audited Results Incomplete.

Performance Overview

Children's Access to Primary Care Practitioners Cohort 3
Ages 7 to 11 years

HFP Population Statistics – *Cohort 3 Age 7 to 11 years*	1999	2000	2001
Number of Plans Reporting	10	23	23
Total Eligible Population	1,070	14,217	51,250
Number of Plans Reporting - Methodology	Admin- 24 Hybrid - 0	Admin- 23 Hybrid - 0	Admin- 23 Hybrid - 0
Range of Scores	Insufficient data	24% - 94%	46% to 94%
Average / Median Score	Insufficient data	67% / 70%	80% / 85%
Aggregate Program Score	**78%**	**74%**	**80%**

Results by Selected Demographic Variables

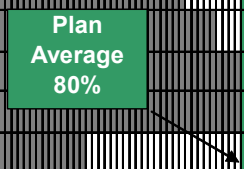
Children's Access to Primary Care Practitioners – Cohort 3					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (20,813)	79%	English(13,687)	81%	1(3,739)	88%
Asian Pacific Islander (4,854)	75%	Spanish(16,274)	78%	2(5,333)	85%
White(4,575)	84%	Vietnamese(354)	74%	3(3,433)	85%
African American(650)	76%	Chinese(2,853)	75%	4(4,628)	80%
American Indian/Alaska Native(78)	83%	Korean(888)	73%	5(10,820)	69%
				6(6,985)	82%

* See Appendix A for definition of regions

Individual Plan Scores

Children's Access to Primary Care Practitioners - Cohort 3
Ages 7 through 11

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	74%	80%	
Alameda Alliance for Health	79%	87%	
Blue Cross - EPO	76%	90%	
Blue Cross - HMO	70%	84%	
Blue Shield - HMO	61%	70%	
CalOptima	62%	74%	
Central Coast Alliance for Health	NM	94%	
Community Health Group	79%	86%	
Community Health Plan	38%	51%	
Contra Costa Health Plan	NM	81%	
Health Net of California	61%	63%	
Health Plan of San Joaquin	85%	83%	
Health Plan of San Mateo	47%	91%	
Inland Empire Health Plan	50%	80%	
Kaiser Permanente	94%	94%	
Kern Family Health Care	69%	88%	
L.A. Care Health Plan	NR	NR	
Molina	61%	66%	
Santa Barbara Regional Health	78%	90%	
Santa Clara Family Health Plan	76%	86%	
San Francisco Health Plan	84%	75%	
Sharp Health Plan	89%	88%	
UHP Healthcare	30%	46%	
Universal Care	84%	85%	
Ventura County Health Care	90%	90%	
			0 10 20 30 40 50 60 70 80 90 100



NM – Not meaningful. Sample size is too small to draw general conclusions.
NR– Not Reportable – Audited Results Incomplete

Follow-up After Hospitalization for Mental Illness

Importance of Measure: According to the National Institute for Mental Health, a significant percentage of individuals experience some form of mental illness, yet only a small percentage are actually diagnosed. For many children, hospitalization often represents the first introduction to mental health services. Regular follow-up therapy is an important component in assuring adequate treatment for patients diagnosed and hospitalized for mental illness.

Calculation: This measure calculates the percentage of subscribers age six and older who were hospitalized for treatment of selected mental health disorders who were continuously enrolled for 30 days after discharge (without gaps) and were seen on an ambulatory basis or were in day/night treatment with a mental health provider. Two scores are generated: 1) the percentage of subscribers who had an ambulatory or day/night mental health visit within *30 days* of hospital discharge, and 2) the percentage of subscribers who had an ambulatory or day/night mental health visit within *7 days* of hospital discharge.

2001 Performance: A factor that may make tracking data difficult for this measure is the mental health "carve out" in the HFP. Children who are suspected of being severely emotionally disturbed (SED) are referred to county mental health departments for assessment and treatment. A health plan's ability to track the necessary information for this measure requires an effective exchange of information with the counties about every health plan's HFP enrollee with SED.

This fact limited the total sample size for this measure to 225 subscribers in 2001 and 112 subscribers in 2000. NCQA recommends that individual plan data not be reported when there is a sample size less than 30. Only one out of 24 participating plans met the minimum sample size, therefore, plan comparisons are not included in this report.

HFP Population Statistics	1999	2000	2001
Number of Plans Reporting	12	11	11
Total Eligible Population	47	112	225
Number of Plans Reporting Methodology	Admin - 11 Hybrid - 1	Admin – 3 Hybrid - 8	Admin – 3 Hybrid - 8
Range of Scores	Insufficient data	Insufficient data	Insufficient data
Average / Median Score	Insufficient data	Insufficient data	Insufficient data
Aggregate Program Score 7 Days 30 Days	 **33%** **55%**	 **21%** **34%**	 **27%** **46%**

120-Day Initial Health Assessment

Importance of Measure: In addition to the HEDIS® measures, MRMIB required participating health plans to provide an additional measure identified as the *120-Day Initial Health Assessment.* This measure was initially developed as a volunteer pilot project through the California Department of Health Services and tested at selected health plans. It is intended to measure whether the primary care practitioner adequately assesses the subscriber's health status and assumes responsibility for the effective management of the subscriber's health care needs.

Calculation: The measure calculates the percentage of subscribers who enrolled during the reporting year and received an initial health assessment within their first 120 days of enrollment. Subscribers eligible for this measure must be two years of age or older upon their effective enrollment date and continuously enrolled for at least 120 days immediately following the effective enrollment date, with no gaps in enrollment.

Changes for 2001: The 120 Initial Health Assessment measure required the use of the *Administrative Method* of data collection for 2001. Prior the 2001, plans had the choice of the *Administrative or Hybrid methods* of data collection.

2001 Performance: This measure encompasses the largest sample of children of all measures presented in this report, with over 220,000 sampled during the 2001 reporting period. Based on the 2001 results, improvements can be seen across the board. Overall aggregate program scores have improved from 37 percent in 1999 to 43 percent in 2000 to 46 percent in the 2001 reporting period. The average of all plans has improved by 10 percentage points over the three year period. The majority of plans (75%+) improved by a least 2 percentage points in 2001, while 5 plans (Alameda Alliance for Health, Blue Shield HMO, Contra Costa Health Plan, Kaiser Permanente and UHP HealthCare) had improvements of at least 10 percentage points.

The demographic analysis of this measure tends to point to better access and availability in small rural counties relative to large urban counties. This is evident in the uniformly higher scores for Region 1 (small counties) as compared to region 5 (Los Angeles) for both the 120 Initial Health Assessment and Access to Primary Care Practitioner measures.

No NCQA benchmarks exist for this measure.

Performance Overview

120-Day Initial Health Assessment

HFP Population Statistics	1999	2000	2001
Number of Plans Reporting	24	24	24
Total Eligible Population	126,012	200,011	224,886
Number of Plans Reporting - Methodology	Admin - 20 Hybrid - 4	Admin- 24 Hybrid - 0	Admin - 24 Hybrid - 0
Range of Scores	1% to 57%	14% to 62%	22% to 76%
Average / Median Score	35% / 39%	39% / 39%	44% / 44%
Aggregate Program Score	**37%**	**43%**	**46%**

Results by Selected Demographic Variables

120-Day Initial Health Assessment					
Ethnicity		Primary Language of Applicant		Geographic Region*	
Latino (124,698)	44%	English (95,586)	48%	1(22,344)	60%
Asian/ Pacific Islander (18,398)	45%	Spanish (94,346)	43%	2(33,414)	55%
White (31,462)	53%	Vietnamese (3,750)	42%	3(17,677)	51%
African American(6,229)	41%	Chinese (6,076)	42%	4(38,747)	46%
American Indian/Alaska Native(938)	47%	Korean (4,355)	47%	5(56,436)	38%
				6(50,464)	40%

(Number in parentheses indicate the number of children in the eligible sample)

* See Appendix A for definition of regions.

Individual Plan Scores

120-Day Initial Health Assessment

Health Plan	2000 Score	2001 Score	2001 Percent
			0 10 20 30 40 50 60 70 80 90 100
Aggregate Program Score	43%	46%	
Alameda Alliance for Health	35%	45%	
Blue Cross - EPO	59%	61%	
Blue Cross - HMO	56%	58%	
Blue Shield - HMO	22%	38%	
CalOptima	28%	36%	
Central Coast Alliance for Health	33%	40%	
Community Health Group	39%	42%	
Community Health Plan	25%	22%	
Contra Costa Health Plan	34%	44%	
Health Net of California	21%	28%	
Health Plan of San Joaquin	62%	60%	
Health Plan of San Mateo	49%	76%	
Inland Empire Health Plan	28%	20%	
Kaiser Permanente	57%	67%	
Kern Family Health Care	48%	50%	
L.A. Care Health Plan	NR	NR	
Molina	25%	33%	
Santa Barbara Regional Health	52%	54%	
Santa Clara Family Health Plan	51%	54%	
San Francisco Health Plan	41%	39%	
Sharp Health Plan	51%	27%	
UHP Healthcare	19%	32%	
Universal Care	41%	44%	
Ventura County Health Care	39%	44%	
			0 10 20 30 40 50 60 70 80 90 100

NR– Not Reportable – Audited Results Incomplete

Endnotes

i. HEDIS is a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to reliably compare the performance of managed health care organizations.

NCQA is an independent, not-for-profit organization dedicated to measuring the quality of America's health care.

ii. Report prepared by Doug Skarr, Managed Risk Medical Insurance Board. For questions, please call (916) 324-7444 or e-mail Dskarr@mrmib.ca.gov.

Appendix A
Description of Geographic Regions Used in this Report

The geographic regions used in this report are based on regions designated by the MRMIB for contract negotiation and program administrative purposes. The counties included in each region are as follows:

Region 1: Alpine, Amador, Butte, Calaveras, Colusa, Del Norte, El Dorado, Glenn, Humboldt, Inyo, Kings, Lake, Lassen, Mendocino, Modoc, Mono, Monterey, Nevada, Placer, Plumas, San Benito, Shasta, Sierra, Siskiyou, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba

Region 2: Fresno, Imperial, Kern, Madera, Mariposa, Merced, Napa, Sacramento, San Joaquin, San Luis Obispo, Santa Cruz, Solano, Sonoma, Stanislaus

Regions 3: Alameda, Contra Costa, Marin, San Francisco, San Mateo, Santa Clara

Region 4: Orange, Santa Barbara, Ventura

Region 5: Los Angeles

Region 6: Riverside, San Bernardino, San Diego

ATTACHMENT 3

2002 Consumer Assessment of Health Plans Survey

2002 Consumer Survey of Health Plans

In the Fall of 2001, the Managed Risk Medical Insurance Board (MRMIB), through a contract with an independent vendor (Datastat), conducted a second consumer survey for the Healthy Families Program (HFP). The survey was conducted to assess the satisfaction and experience families were having with participating health plans and to provide existing and potential HFP applicants with information about their health plan options. This report summarizes the results from the survey.

SURVEY METHODOLOGY

The survey was conducted using the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS)®2.0H instrument which contains 72 questions pertaining to nine aspects of care. The aspects of care that were covered in the survey include access to care, customer service, communication of providers, and quality and satisfaction of health plan services and health care received. The responses to the survey questions were summarized into four global ratings and five composite scores. The global ratings included ratings of health care, health plan, regular doctor or nurse, and specialist. The composite scores addressed getting needed care, getting care quickly, how well doctors communicate, helpfulness and courteousness of doctor's office staff and customer service.

The survey was conducted in five languages--English, Spanish, Vietnamese, Korean and Chinese. The instruments in the Asian languages were made available for use through the support of the California Medi-Cal Policy Institute in 2000.

THE SURVEY SAMPLE

A random sample of families was selected according to NCQA (National Committee for Quality Assurance) protocols for conducting the survey. Families with children ages 12 years and younger, who had been continuously enrolled in the plan for at least six months as of June 30, 2001 were selected from each participating health plan. Twenty-six health plans were included in the survey. The target sample size for health plans was 1,050. Eighteen plans had sufficient HFP enrollment to provide the target sample. For the eight plans that did not have sufficient enrollment, all subscribers who met the criteria were surveyed. Table 1 shows the number of families who were selected for the survey for each participating health plan.

Table 1 – Families Surveyed From Each Health Plan

Health Plan	Number of families surveyed
Alameda Alliance for Health	1,050
Blue Cross – EPO	1,050
Blue Cross – HMO	1,050
Blue Shield – EPO	179
Blue Shield – HMO	1,050
CalOptima	1,050
Care 1st Health Plan	456
Central Coast Alliance for Health	355
Community Health Group	1,050
Community Health Plan	1,050
Contra Costa Health Plan	564
Health Net	1,050
Health Plan of San Joaquin	1,050
Health Plan of San Mateo	259
Inland Empire Health Plan	1,050
Kaiser Permanente	1,050
Kern Family Health Care	1,050
LA Care Health Plan	1,050
Molina	1,050
San Francisco Health Plan	1,050
Santa Barbara Regional Health Auth.	460
Santa Clara Family Health Plan	1,050
Sharp Health Plan	1,050
UHP Healthcare	614
Universal Care	1,050
Ventura County Health Plan	905
Total Program	**22,692**

Families selected for the survey received the survey in English, and Spanish, Korean, Vietnamese or Chinese if one of these languages was designated as the primary language on the families' HFP application. Table 2 outlines the distribution of the survey instruments mailed in each language for each health plan.

Table 2 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Alameda Alliance	1,050	341	435	237	9	28
Blue Cross - EPO	1,050	550	485	6	4	5
Blue Cross - HMO	1,050	461	431	93	55	10
Blue Shield - EPO	179	147	30	0	1	1
Blue Shield - HMO	1,050	586	324	68	61	11
CalOptima	1,050	186	738	3	32	91
Care 1st Health Plan	456	110	343	2	0	1
Central Coast Alliance for Hlth.	355	93	260	2	0	0
Community Health Group	1,050	291	741	6	0	12
Community Health Plan	1,050	235	741	60	4	10
Contra Costa Health Plan	564	166	397	1	0	0
Health Net	1,050	531	443	57	6	13
Health Plan of San Joaquin	1,050	514	515	17	0	4
Health Plan of San Mateo	259	69	184	5	1	0
Inland Empire Health Plan	1,050	388	655	1	1	5
Kaiser Permanente	1,050	612	412	19	4	3
Kern Family Health Care	1,050	452	595	0	3	0
LA Care Health Plan	1,050	241	770	28	10	1
Molina	1,050	275	775	0	0	0
San Francisco Health Plan	1,050	170	200	675	1	4
Santa Barbara Regional Health Auth.	460	136	324	0	0	0
Santa Clara Family Health Plan	1,050	246	664	12	0	128
Sharp Health Plan	1,050	539	486	6	3	16
UHP Healthcare	614	196	325	30	56	7
Universal Care	1,050	249	776	0	3	22
Ventura County Health Plan	905	196	709	0	0	0

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

THE SURVEY PROCESS

The survey was conducted using the Medicaid CAHPS® 2.0H survey protocol. Datastat conducted the survey over an 8-week period using a mixed-mode (telephone and mail) five-step protocol between the months of August and November 2001. The five-step protocol consisted of a pre-notification mailing and initial survey mailing, a reminder postcard to all respondents and a second survey mailing and second reminder postcard to non-respondents. Telephone follow-up was conducted for non-respondents in English and Spanish only. (The protocol for conducting the telephone follow-up in the Asian languages was not available for this survey.) The timeline for the survey is presented in Table 3.

Table 3 – Survey Timeline

Pre-notification letter mailed	September 4, 2001
First questionnaire with cover letter mailed	September 14, 2001
Reminder postcard to non-respondents mailed	September 20, 2001
Second questionnaire and letter mailed to non-respondents	October 12, 2001
Second reminder postcard mailed to non-respondents	October 18, 2001
Telephone follow-up is conducted for non-respondents	October 29, 2001
Survey ends	November 26, 2001

The pre-notification and follow-up correspondences were developed based on recommended samples from the CAHPS®2.0H protocol.

SURVEY RESULTS

Response Rates

The response rate for the survey was 62.4 percent. The response rates were calculated by eliminating the number of families in the initial mailing that had incorrect addresses and telephone numbers or who did not meet the requirements for the survey. The number of usable surveys was calculated by taking the number of surveys that were completed according to CAHPS® 2.0H protocol for conducting the survey. For this survey, 1,548 surveys were eliminated from the 22,692 surveys mailed, resulting in a net usable 21,144

surveys. Of these surveys, a total of 13,191 surveys were returned. Table 4 shows the response rates for each participating health plan.

Table 4 -- Response Rates for Each Health Plan

Health Plan	Number of families surveyed	Number of Usable Surveys	Number of usable responses	Response Rate
Alameda Alliance for Health	1,050	973	615	63.2%
Blue Cross EPO	1,050	988	662	67.0%
Blue Cross HMO	1,050	978	606	62.0%
Blue Shield EPO	179	157	111	70.7%
Blue Shield HMO	1,050	975	654	67.1%
CalOPTIMA	1,050	966	555	57.5%
Care 1st Health Plan	456	414	255	61.6%
Central Coast Alliance for Health	355	324	189	58.3%
Community Health Group	1,050	982	642	65.4%
Community Health Plan	1,050	943	547	58.0%
Contra Costa Health Plan	564	528	334	63.3%
Health Net	1,050	993	612	61.6%
Health Plan of San Joaquin	1,050	978	600	61.3%
Health Plan of San Mateo	259	241	152	63.1%
Inland Empire Health Plan	1,050	987	656	66.5%
Kaiser Permanente	1,050	990	624	63.0%
Kern Family Health Plan	1,050	979	630	64.4%
L.A. Care Health Plan	1,050	960	577	60.1%
Molina	1,050	985	621	63.0%
San Francisco Health Plan	1,050	972	526	54.1%
Santa Barbara Region Health Auth.	460	432	298	69.0%
Santa Clara Family Health Plan	1,050	982	603	61.4%
Sharp Health Plan	1,050	990	668	67.5%
UHP Healthcare	614	572	343	60.0%
Universal Care	1,050	1000	575	57.5%
Ventura County Health Plan	905	855	536	62.7%
Total	**22,692**	**21,144**	**13,191**	**62.4%**

The response rate for the 2001 survey (62.4%) was slightly lower than the response rate for the 2000 survey (64.5%).

Summary of Responses

The responses to the survey were summarized into four rating and five composite questions. Responses that indicate a positive experience were considered achievement scores. Charts displaying the survey results by health plan are presented beginning on page 6 of this report.

Rating Questions Responses: For the four rating questions, a 10-point scale was used to assess overall experience with health plans, providers, specialists and health care. The achievement scores for these questions were determined by the percentage of families that responded to each question based on an 8, 9 or 10 rating. Individual plan scores for the 2001 survey are compared with the overall program score in 2001 and 2000 and a *benchmark*. This benchmark is based on the highest score achieved by a participating health plan with a minimum of 75 responses.

The results of the survey indicated that approximately 80 percent of families rated their health care, health plan, personal doctor (or nurse) and specialist an 8, 9 or 10. The highest score achieved for the program was in the rating of health plan at 84 percent. The lowest health plan rating scores were 63 percent for the rating of personal doctor or nurse.

The percentage of families rating their health plan an 8, 9, or 10 ***increased*** in 2001. In the 2000 survey 83.2 percent of families gave their plans a high rating. In the 2001 survey, 85 percent gave their plan a high rating. Other year to year differences were not significantly different.

Composite Score Results: For the composite scores, the composite question is grouped with other questions that relate to the same broad domain of performance. For example, "getting care quickly" includes questions about getting advice by phone, about how soon appointments were scheduled, and about time spent waiting in the doctor's office. The achievement score for these questions is determined by the percentage of families who respond positively to each question. A response is considered positive if the answers are "not a problem" for the questions comprising the *Getting Needed Care* and *Customer Service* composites, and "usually" and "always" for the *Getting Care Quickly*, *How Well Doctors Communicate*, and *Courteous and Helpful Office Staff* composites.

The survey questions that make up the composite cores are listed below.

"Getting Needed Care"

- Able to get a personal doctor or nurse for child you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's health care while awaiting approval

"Getting Care Quickly"

- Usually or always got help of advice needed of child
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for an illness/injury as soon as wanted
- Child never or sometimes waited more than 15 minutes in the doctor's office or clinic

"How Well Doctor's Communicate"

- Doctors usually or always listened carefully
- Doctors usually or always explained things in an understandable way
- Doctors usually or always showed respect
- Doctors usually or always spent enough time with child

"Courteous and Helpful Office Staff"

- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

"Customer Service"

- Able to find or understand information in written materials
- Able to get help needed when you called child's health plan's customer service

For most of the composite ratings, approximately 80 percent of families responded positively. The composite rating with the highest percentage of families responding positively was for *How Well Doctor's Communicate* questions, at 87 percent. The composite rating with the lowest percentage of families responding positively was *Getting Care Quickly* at 69 percent.

A comparison of composite scores from the 2001 and 2000 survey did not yield any significant differences.

With respect to health plan scores, the highest composite score achieved was at 94 percent and was for the *How Well Doctor's Communicate* composite. The lowest score achieved by a health plan was 61 percent for the *Getting Care Quickly* composite.

SURVEY RESULTS FOR PARTICIPATING HEALTH PLANS

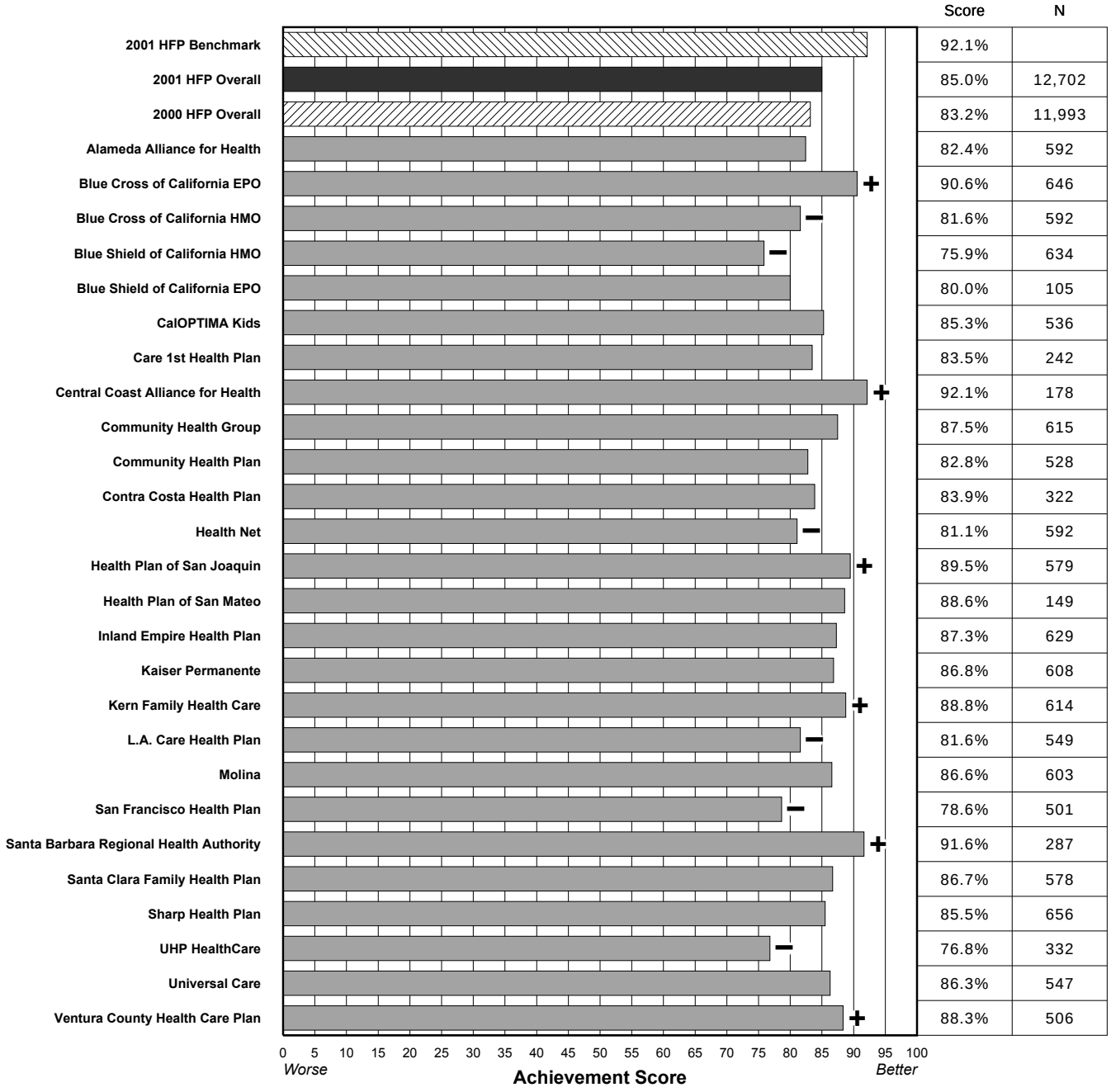
The results for each participating health plan is presented in the following charts. Plans that have achievement scores significantly higher or lower than the program score are indicated by a "+" or "-" next to their scores.

Based on an oversampling of families who received the survey in Chinese, Vietnamese and Korean in 2000, it appears that families responding in these languages respond less favorably than families responding in English and Spanish. This difference in responses among language groups may affect the scores of participating health plans with a large number of subscribers whose primary language is one of the Asian languages.

At the time this report was prepared, a method to account for differences in responses due to language was not available. However, MRMIB has been working with RAND to understand these differences and expects to have some useful information from RAND's efforts by the end of the year.

Overall Ratings

Q60. Overall rating of health plan

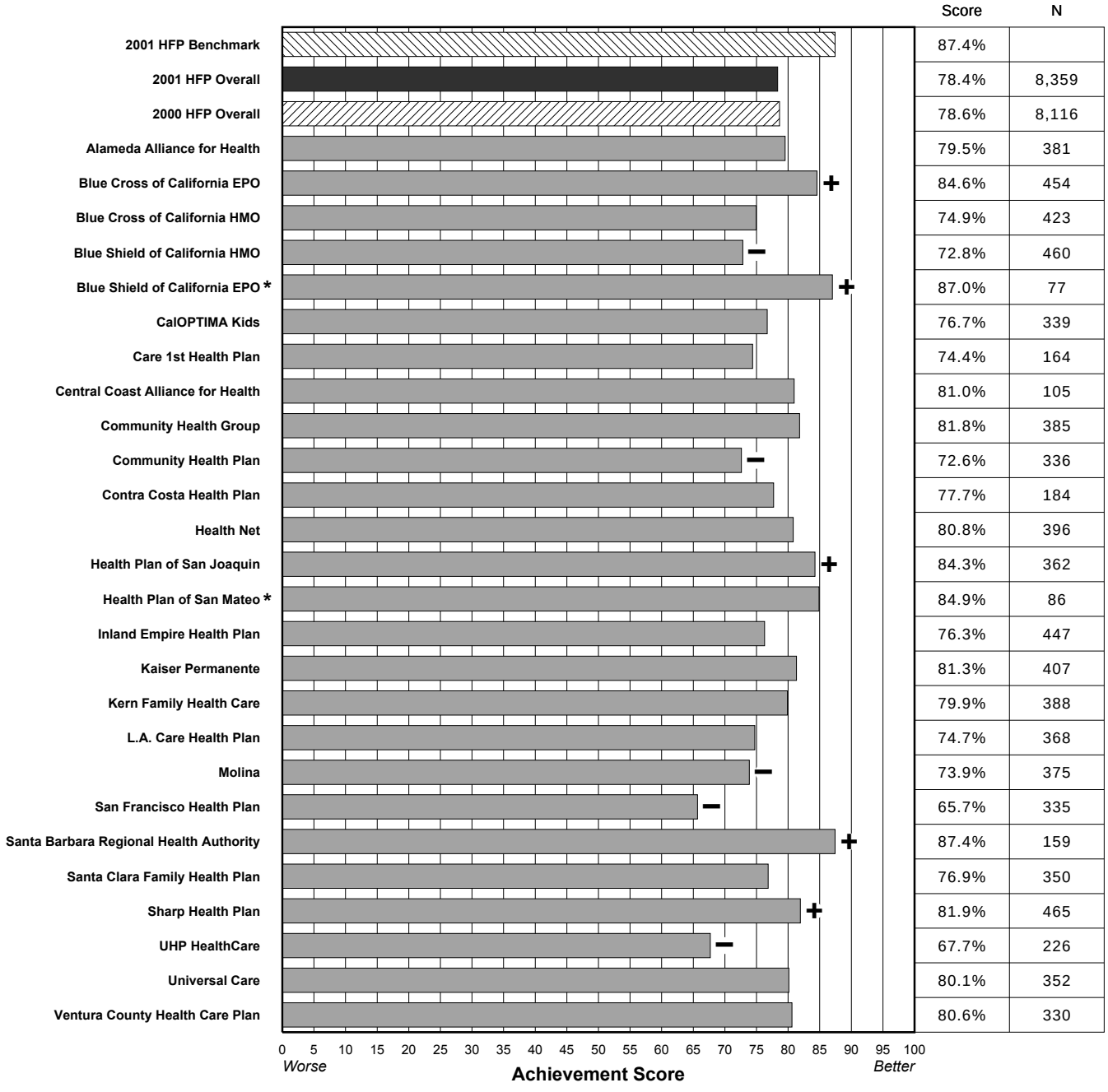


+/- Statistically significantly higher/lower than 2001 HFP Overall

2001 HFP Benchmark 2000 HFP Overall Health Plans
2001 HFP Overall

Overall Ratings

Q36. Overall rating of health care



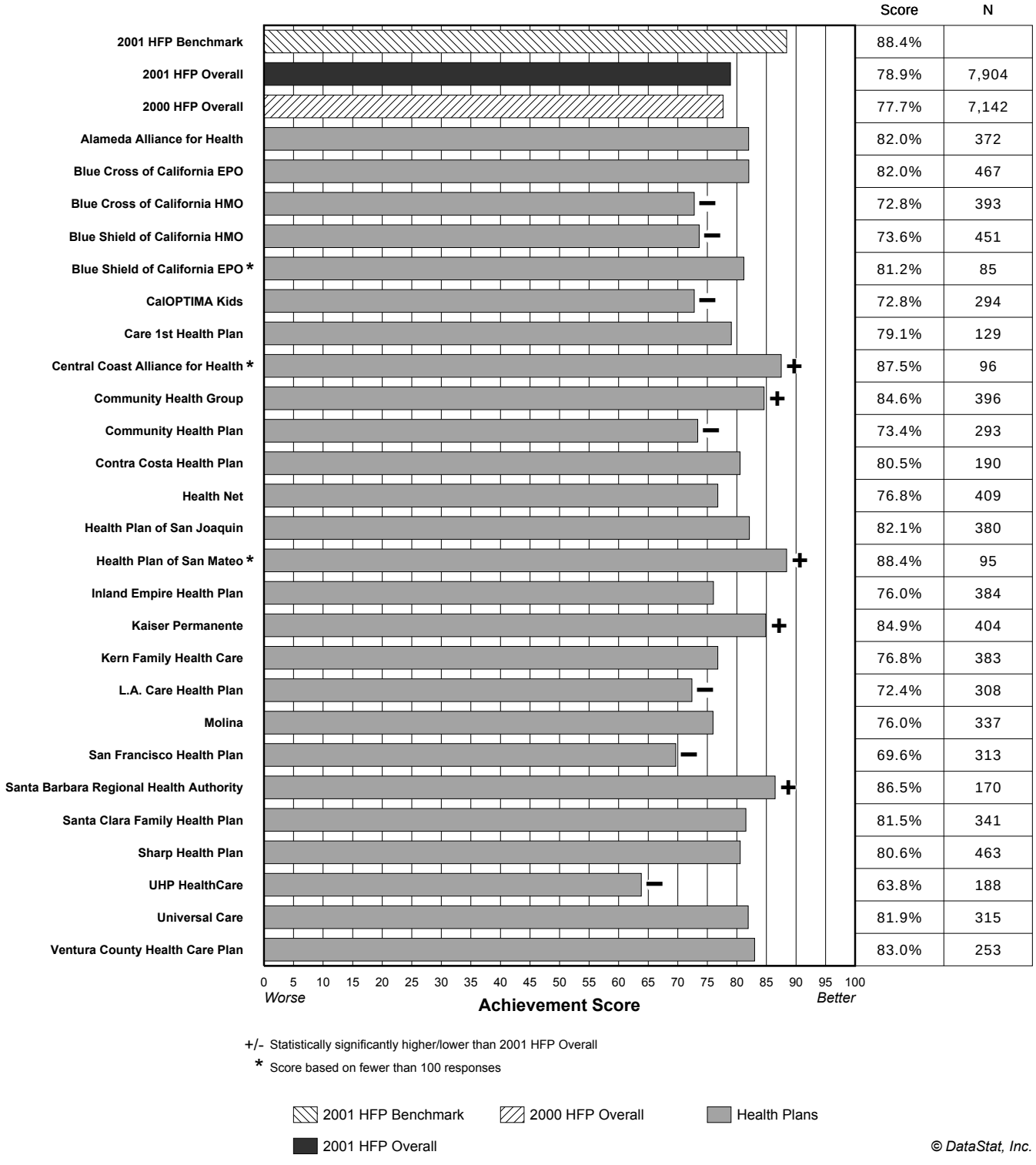
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

Overall Ratings

Q7. Overall rating of personal doctor or nurse



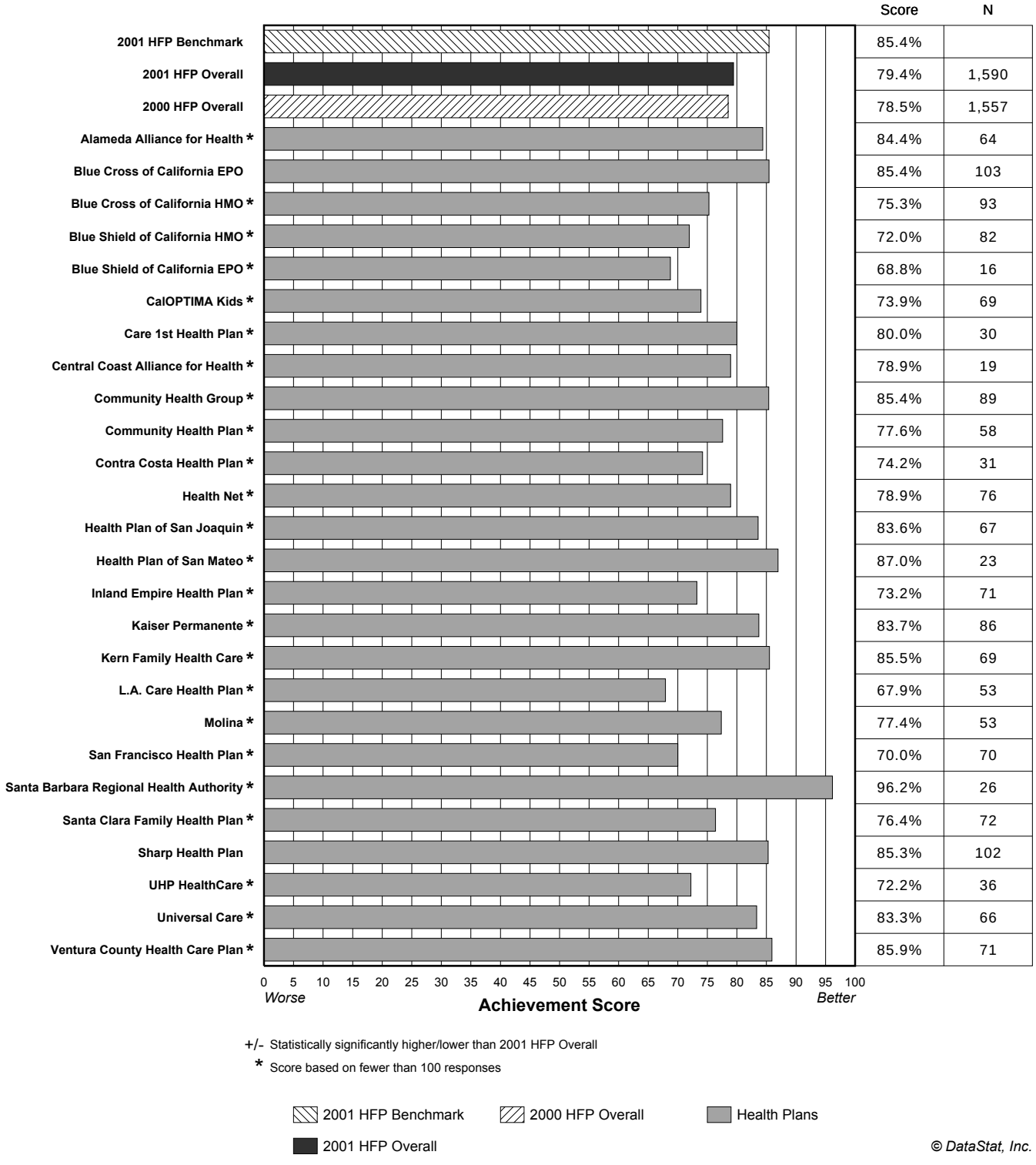
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

Overall Ratings

Q11. Overall rating of specialist



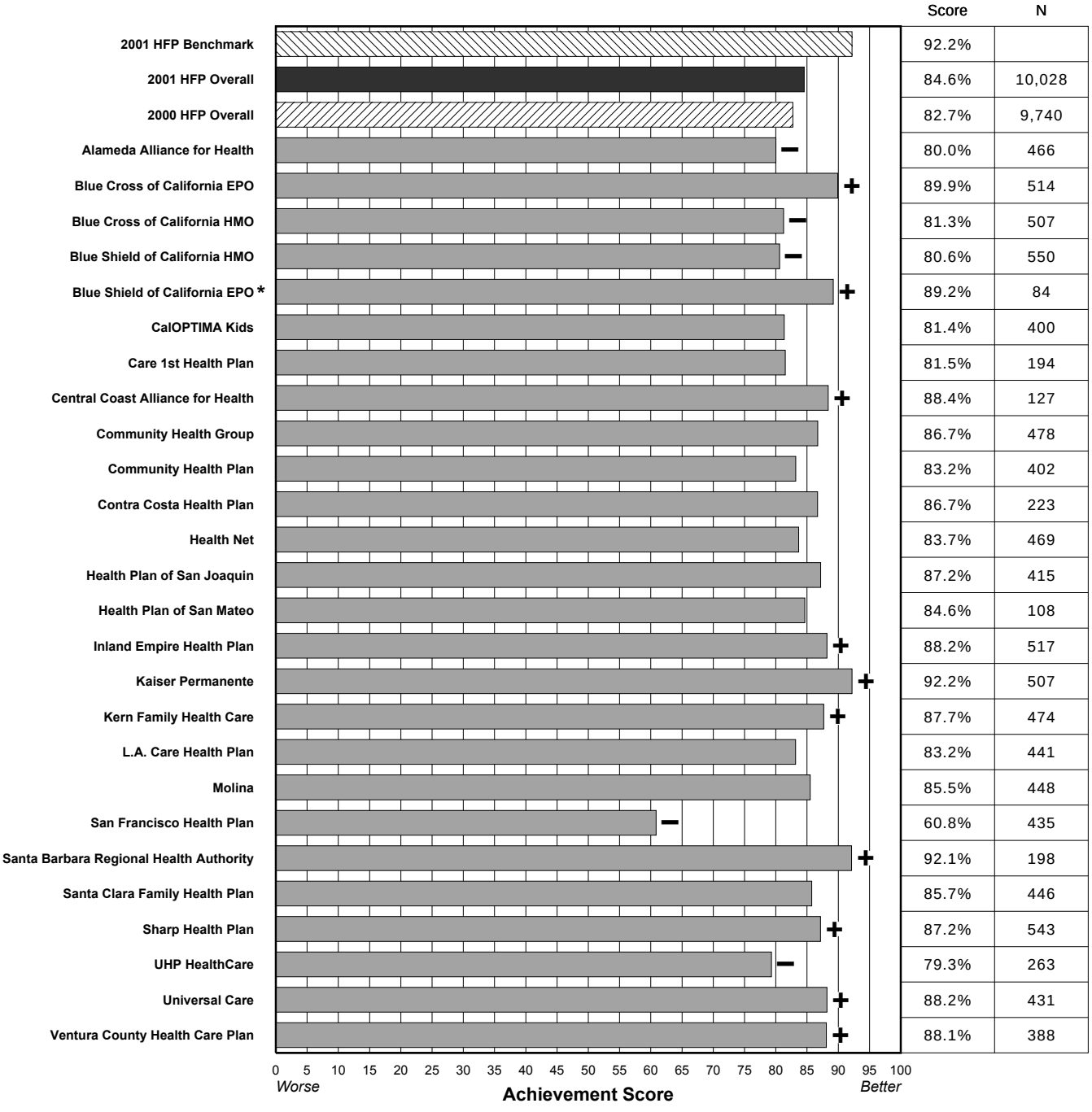
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

Getting Needed Care

Composite Score



+/- Statistically significantly higher/lower than 2001 HFP Overall

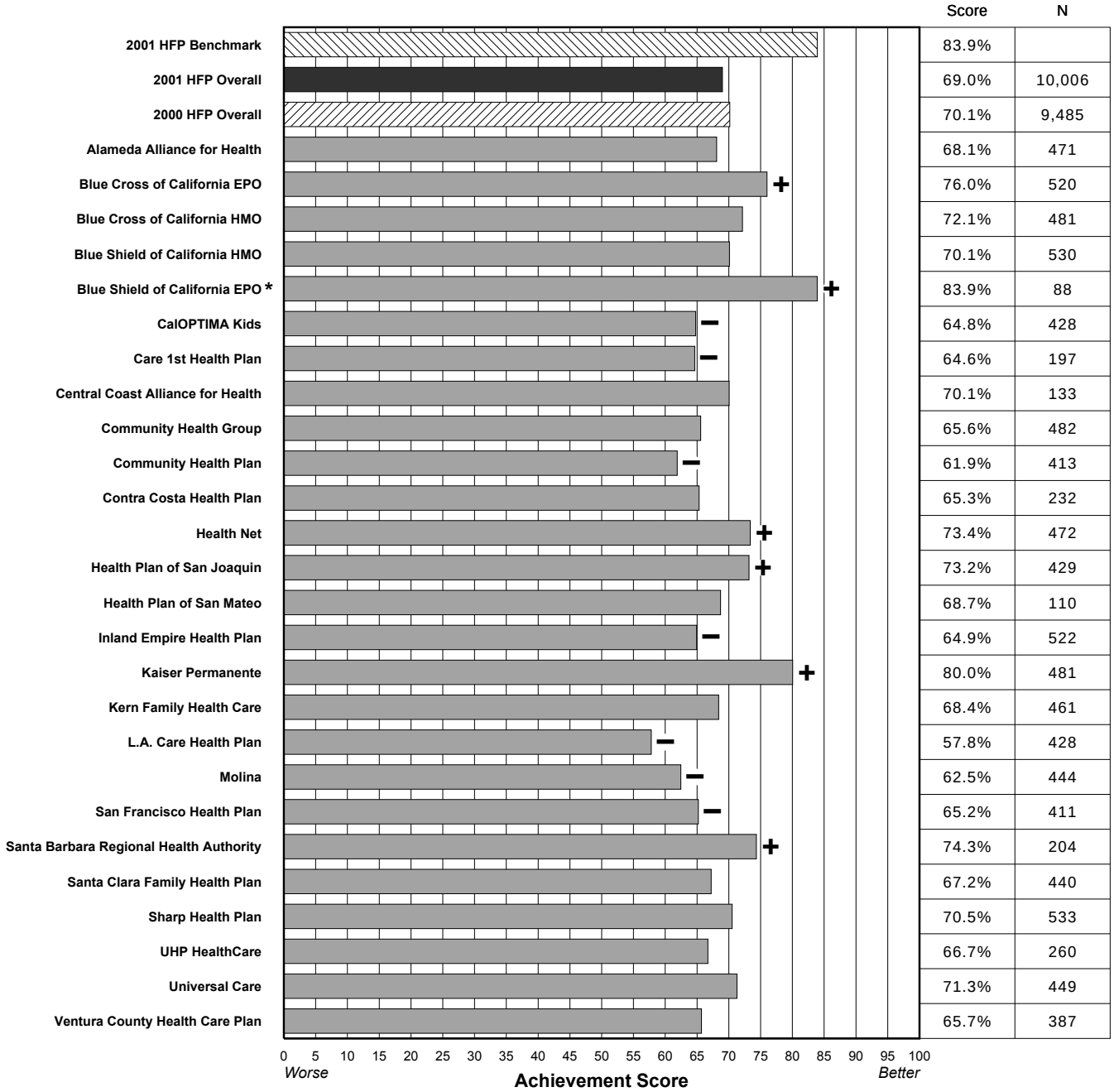
* Score based on fewer than 100 responses

2001 HFP Benchmark 2000 HFP Overall Health Plans

2001 HFP Overall

Getting Care Quickly

Composite Score



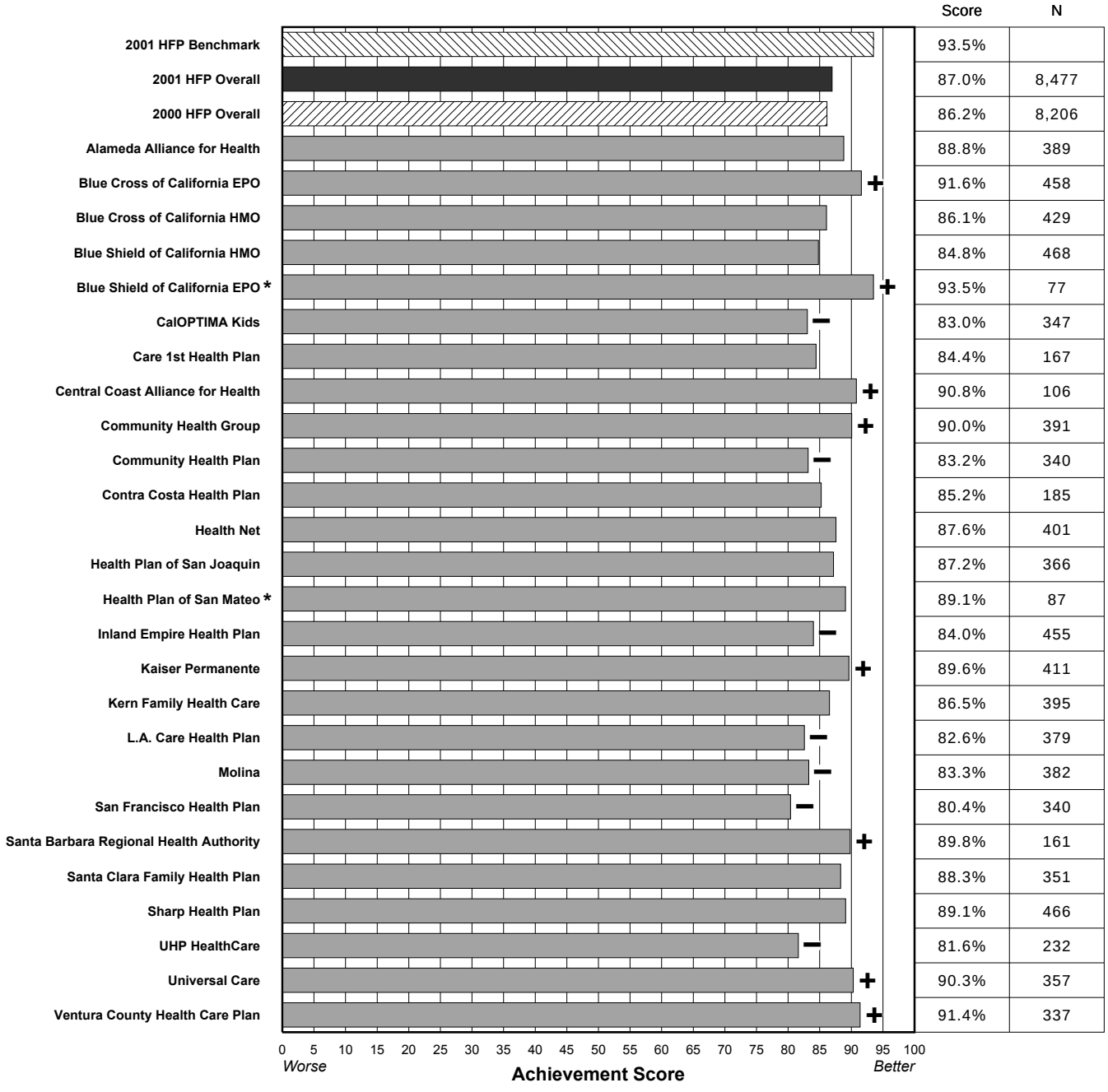
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

How Well Doctors Communicate

Composite Score



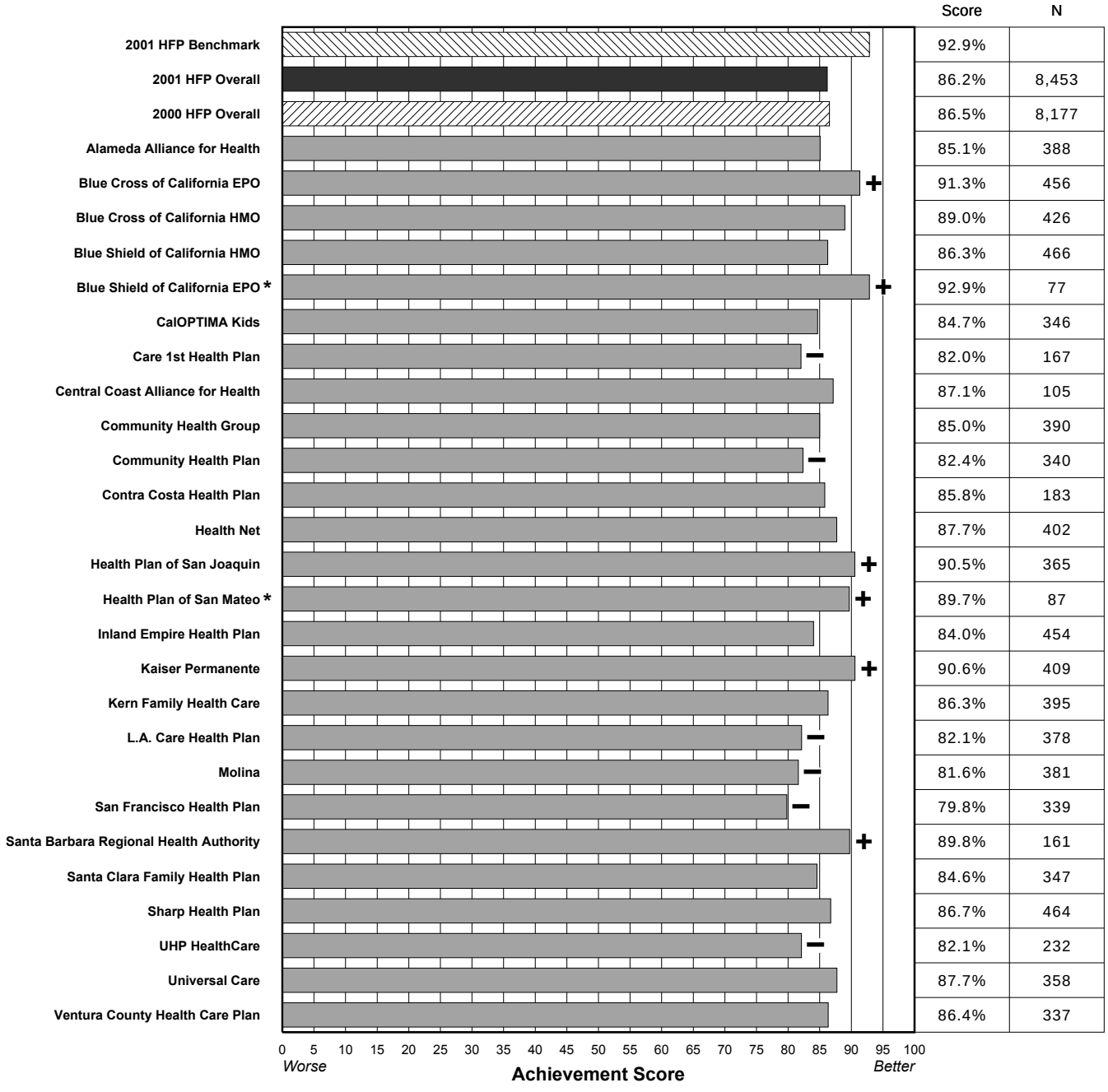
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

Courteous and Helpful Office Staff

Composite Score



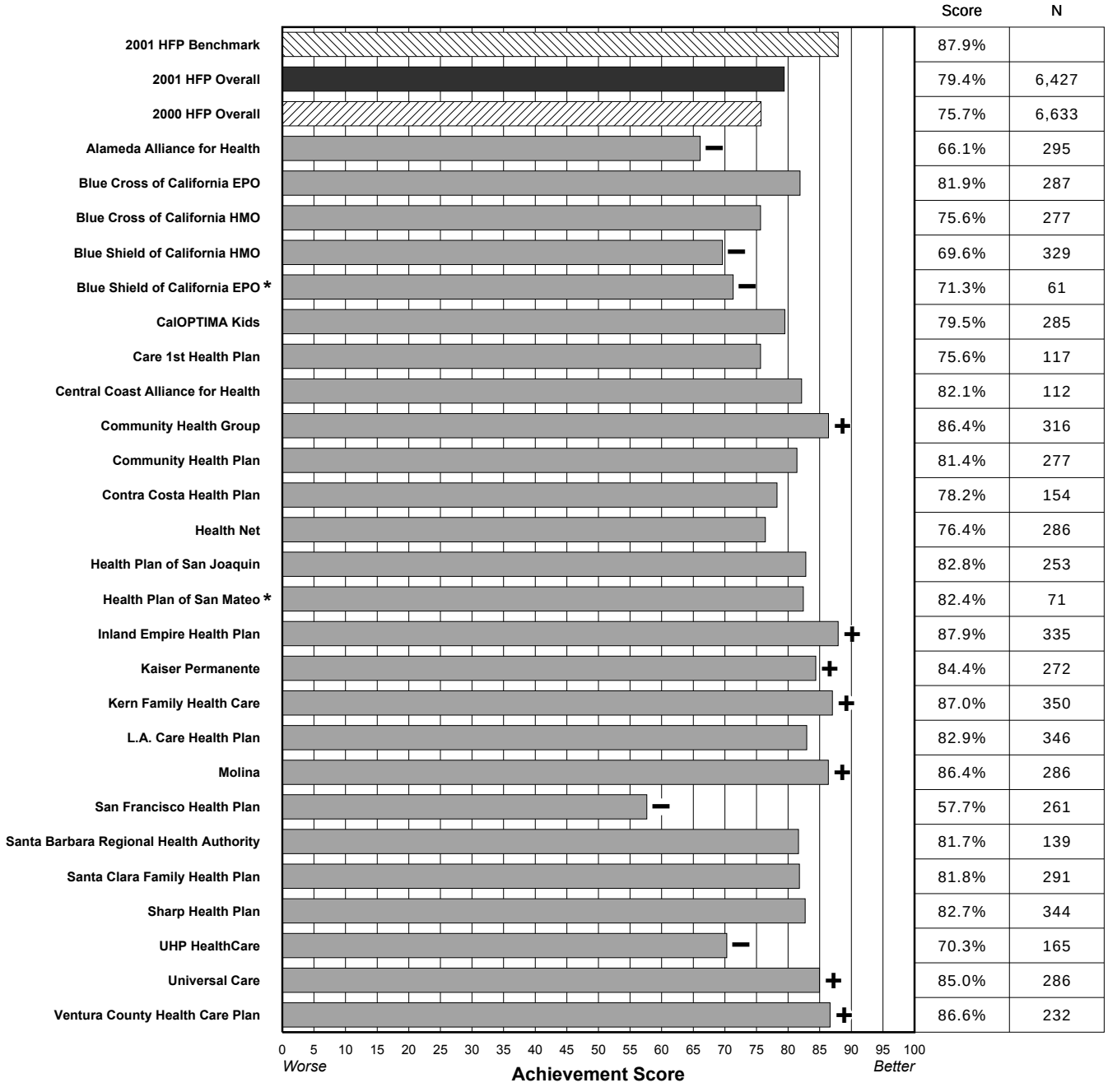
+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark | 2000 HFP Overall | Health Plans | 2001 HFP Overall

Customer Service

Composite Score



+/- Statistically significantly higher/lower than 2001 HFP Overall

* Score based on fewer than 100 responses

2001 HFP Benchmark 2000 HFP Overall Health Plans

2001 HFP Overall

ATTACHMENT 4

Health Status Assessment Year 1 Report

Health Status Assessment Project – First Year Results

The Health Status Assessment Project is a three-year longitudinal survey that will allow the Managed Risk Medical Insurance Board (MRMIB) to evaluate the health status of children newly enrolled in the Healthy Families Program. The project examines the physical and psychosocial benefits of having access to comprehensive medical, dental and vision insurance.

The project is being conducted by MRMIB in partnership with researchers at the Center for Child Health Outcomes, Children's Hospital and Health Center, San Diego. Financial support is provided by the David and Lucile Packard Foundation.

The methodology used to assess changes in health status is based on recommendations from the HFP Quality Improvement Workgroup. The Workgroup selected the PedsQL™ 4.0 (Pediatric Quality of Life Inventory™ Version 4.0) as the tool to measure health status.

The PedsQL™ is a simple questionnaire that asks children (ages 5-18) and their parents (of children ages 2-18) about their perceptions of the child's health-related quality of life. The survey asks how much of a problem each item has been during the past one month.

A 5-point response scale is utilized (0 = never a problem; 1 = almost never a problem; 2 = sometimes a problem; 3 = often a problem; 4 = almost always a problem). Items are reverse-scored and linearly transformed to a 0-100 scale (0 = 100, 1 = 75, 2 = 50, 3 = 25, 4 = 0). Higher scores indicate better health-related quality of life.

The survey procedure includes the initial survey mailing, reminder postcard mailing, non-response second survey mailing and non-response phone follow-up.

The tool was selected because of its length (23 questions), short time to complete and the ability to use the instrument for all Healthy Families Program age groups.

Research has shown that health-related quality of life surveys are a reliable and valid measure of health status and that parent's perception of their child's health is a reliable indicator of the child's health status. (A detailed description of the PedsQL™ 4.0 is included as Appendix A)

Survey Design

The study was conducted by mailing the PedsQL™ 4.0 questionnaire to subscribers and their parents during the subscribers first month of enrollment. Twenty-thousand (20,000) subscribers who were newly enrolled in the months of February and March 2001 were selected for the survey. Questionnaires were mailed to the families in five languages (English, Spanish, Vietnamese, Korean or Chinese) based on the language of the applicant.

Results of the returned questionnaires were compiled and analyzed to develop a **baseline** measurement of health status. The identical questionnaire was mailed during February and March of 2002 to the sample subscribers who remained in the HFP over the one-year period or **year 1.** The data collected for **year 1** was compared with the **baseline** data to measure changes in health status.

Survey Measures

Demographic variables examined in this study include age, gender, language, ethnicity and the presence of a chronic health condition. In addition to demographic variables, the relationship between a subscriber's use of services and health-related quality of life was examined.

I - Survey Sample

Response Rates

Packets containing the PedsQL™ 4.0 survey instrument were mailed to 20,031 families during February and March 2001. A total of 10,241 families (51%) returned the baseline survey.

Of these 10,241 members surveyed during their initial month of enrollment, 6,881 (67%) remained in the Healthy Families Program for one year. This retention rate (67%) is similar to the experience of the entire Healthy Families Program population.

- **Of the 6,881 respondents remaining in the program after one year, over 87% (6,005) completed the year 1 survey.**

The ethnicity, language, age and gender distribution of the sample matches those of the overall HFP population.

African-American and White parents were *less* likely to complete the survey, and Latino and Asian/Pacific Islanders parents were significantly *more* likely to complete the survey.

English survey respondents were less likely to complete the survey and Spanish survey respondents were more likely to complete the survey.

Table 1 presents the sample characteristics by age, language and ethnicity of the survey response rates for baseline and year 1.

Table 1. Sample counts and response rates by age, language and ethnicity

	Baseline		Year 1	
	Response Rate	% of Sample	Response Rate	% of Sample
AGE				
Toddler (2-4)	59%	30.5%	89%	19.45%
Young Child (5-9)	48%	24.3%	87%	25.98%
Child (8-12)	50%	31.4%	87%	35.20%
Adolescent (13-16)	47%	13.8%	87%	19.57%
LANGUAGE				
English	44%	43.0%	83%	38.57%
Spanish	58%	50.7%	91%	53.91%
Chinese	58%	3.3%	84%	1.43%
Korean	55%	1.7%	85%	2,31%
Vietnamese	56%	1.4%	85%	3.98%
ETHNICITY				
White	46%	13.7%	82%	12.61%
Latino	53%	61.5%	89%	62.21%
Black/African-American	37%	2.3%	79%	1.92%
Asian/Pacific Islander	54%	11.8%	82%	12.36%
Native American	46%	0.4%	89%	.4%
Not Reported	50%	10.3%	85%	9.84%

Note: Language refers to language of questionnaire

Retention Rates After One Year

Table 2 on page 3 shows several variables that might influence retention and compares the differences between those children who remained enrolled in the Healthy Families Program to those who dropped out prior to their one year anniversary.

Asian/Pacific Islander children were less likely to drop out than children in other race/ethnic categories. Families completing the survey in a language other than English were less likely to drop out of the Healthy Families Program.

There was no difference in retention between children with a personal physician versus those without. However, those reporting problems getting necessary care and incidents of foregone health care were slightly more likely to drop out of the Healthy Families Program.

Children with and without chronic health conditions were retained at the same rate.

Table 2. Children enrolled for one year verses children who dropped out of program prior to one year anniversary

Demographic Variables	Still enrolled after one year	Dropped Out prior to one year anniversary
	(n=6881)	(n=3360)
Race/Ethnicity		
White	13.3%	14.6%
Latino	61.3%	62.0%
African-American	2.1%	2.8%
Asian /Pacific Islander	12.7%	9.8%
Native American	0.4%	0.4%
Not Reported	10.1%	10.5%
Language		
English	41.2%	46.5%
Other	58.8%	53.5%
Had a Personal Physician		
Yes	57.0%	56.9%
No	43.0%	43.1%
Had Problems Getting Care		
Yes	20.4%	22.6%
No	79.6%	77.4%
Reported Incidence of Foregone Care		
Yes	17.3%	19.5%
No	82.7%	80.5%
Reported a Chronic Health Condition		
Yes	8.5%	9.2%
No	91.5%	90.8%
PedsQL™ Total Score		
Parent Proxy-report	81.32	81.39

II - Baseline - Health status profile of children entering the Healthy Families Program

Overall Baseline Scoring

- Prior research shows that healthy children, on average, score **83** on the PedsQL™ 4.0 survey instrument.

Table 3 presents the total number of responses received for each item, and the mean and standard deviation of the PedsQL™ 4.0 scale scores for the total baseline sample.

Table 3. Baseline PedsQL™ 4.0 Scores Child Self-Report and Parent Proxy-Report

Scale	Number of Responses Received	Mean	SD
Parent Proxy			
Total Score	10,066	**81.38**	15.90
Physical Health	10,050	83.26	19.98
Psychosocial	10,067	80.25	15.82
Emotional	10,044	80.28	16.99
Social Functioning	10,036	82.15	20.08
School	8,466	76.91	20.16

- Children enrolled in the Healthy Families Program have experienced health-related quality of life similar to that reported for the general child population.

Results from the baseline period indicated that 18 percent (1,949) of the sample children fell within *one standard* deviation below the mean, while 4 percent (454) fell within *two standard* deviations below the mean.

The authors of the PedsQL™ survey instrument indicate that children who fall below one standard deviation are "at risk". For example, if a child's score falls one standard deviation below the mean, monitoring and possible medical intervention should be considered, while scores two standard deviations below the mean require immediate medical intervention.

Baseline Scores by Selected Demographics

Table 4 contains a summary analysis, delineated, by selected member characteristics (age, language and ethnicity). There was a slight correlation between age and parent proxy-report PedsQL™ 4.0 scores, such as the parents of older children tended to view them as having slightly lower health-related quality of life.

Comparing baseline scores among language groups, parents responding in Spanish report significantly lower PedsQL™ 4.0 scores for their children than do parents responding in English, Korean and Chinese, who in turn report lower scores than parents responding in Vietnamese.

Table 4. Summary PedsQL™ 4.0 Scores by Selected Demographics

Category	Baseline Score	
	Mean	SD
AGE		
Toddler (2-4)	87.47	12.44
Young Child (5-9)	78.05	16.44
Child (8-12)	78.88	16.60
Adolescent (13-16)	79.48	16.38
LANGUAGE		
Spanish	79.23	17.12
English	83.49	14.18
Chinese	83.22	13.91
Korean	82.88	15.82
Vietnamese	87.35	15.57
ETHNICITY		
White	84.53	13.40
Latino	80.44	16.45
Black/African American	82.90	1363
Asian/Pacific Islander	82.32	15.70
Native American	83.75	15.79
Not Reported	81.17	15.77

At Baseline, how did access to care affect perceived health-related quality of life?

Associations between access to services and health-related quality of life (PedsQL™ scores) are described below. Parent reports of instances during the past 12 months when they had problems ***getting care for their child that they or a physician felt was necessary*** were tracked and analyzed to determine the correlation. The following question was posed to parents:

"In the last 12 months, how much of a problem, if any, was it to get care for your child that you or a doctor believed necessary?"

Table 5 shows PedsQL™ 4.0 parent proxy-report scores for children experiencing problems ***getting care*** versus those who did get care in the 12 months prior to enrolling in the Healthy Families Program.

Table 5. PedsQL™ 4.0 Generic Core Scores Problems getting necessary care for the child in the year prior to enrolling in HFP

	No Problems		Yes Problems	
Scale	N	Mean	N	Mean
Total Score	7664	**82.67**	2044	**76.65**
Physical Health	7650	84.43	2042	79.05
Psychosocial	7669	81.62	2042	75.27
Emotional	7648	81.59	2039	75.05
Social Functioning	7647	83.48	2036	77.53
School	6405	78.38	1751	71.74

- There is a correlation between the ability of subscribers to access care and their overall health-related quality of life. In the year prior to enrolling in the Healthy Families Program, approximately 20 percent of the families identified a problem in receiving needed care for their child. Children identified with a chronic condition were twice as likely to experience an access problem.

At Baseline, how did chronic conditions affect perceived health-related quality of life?

Table 6 contains the PedsQL™ 4.0 baseline scores for healthy children and children with a chronic health condition in the sample.

Table 6. PedsQL™ 4.0 Baseline Scores Children with and without a reported chronic condition

Scale	Did not report a chronic condition		Reported a chronic health condition	
Parent Proxy	**N**	**Mean**	**N**	**Mean**
Total Score	8709	**82.32**	831	**73.18**
Physical Health	8696	84.08	830	76.99
Psychosocial Health	8711	81.27	830	71.08
Emotional	8692	81.20	829	71.08
Social Functioning	8690	83.05	824	75.06
School Functioning	7287	78.27	756	65.58

These conditions included, but were not limited to Asthma, Attention Deficit Hyperactivity Disorder (ADHD) and Depression.

Approximately 9 percent of the subscribers surveyed indicated their child had a chronic condition. This observation is important because these children experience significantly lower health-related quality of life along all five dimensions (physical, psychosocial, emotional, social functioning and school functioning), than children who were not reported to have a chronic health condition.

Baseline access to care results for children with and without reported chronic health conditions

In the 12 months prior to enrolling in the Healthy Families Program comparing chronic versus healthy populations, families report they are twice as likely to have problems getting care and receiving care if their child had a chronic condition. The health related quality of life of those children whose parents reported access barriers was significantly less than that of children who did not face these access barriers.

Table 7 compares the number and percentage of subscribers reporting problems getting care by whether the family reports a chronic condition.

Table 7. PedsQL™ 4.0 Generic Core Scores Problems getting care – with and without a chronic health condition

Category	**No** problem getting care	**Yes** problem getting care
Without a Chronic Health Condition		
Number in Sample	6,839	1,644
Percent of Sample	81%	19%
With a Chronic Health Condition		
Number in Sample	513	316
Percent of Sample	62%	38%

Children in the Lowest Quartile

Children were defined in the *lowest quartile* based on PedsQL™ Total Scores at baseline. This cutoff score was 71.74.

Table 8 compares baseline data for children in the *lowest quartile* with children above the *lowest quartile*. The data is for those families who responded to the year 1 follow-up survey.

Table 8. Children in lowest vs. top three quartiles recorded in baseline study.

Category	Lowest Quartile	Top Three Quartiles
Race/Ethnicity		
White	8.1%	14.2%
Latino	66.8%	61.2%
Black/African American	1.1%	2.2%
Asian / Pacific Islander	13.2%	12.2%
Native American	0.3%	0.4%
Not Reported	10.5%	9.7%
Language		
English	29.1%	42.7%
Other	70.9%	57.3%
Had a Personal Physician		
Yes	52.3%	57.8%
No	47.7%	42.2%
Had Problems Getting Care		
Yes	29.0%	16.9%
No	71.0%	83.1%
Reported Incidence of Foregone Care		
Yes	25.1%	14.3%
No	74.9%	85.7%
Reported Chronic Health Condition		
Yes	14.9%	6.5%
No	85.1%	93.5%
PedsQL™ Total Score		
Parent Proxy-report	58.07	88.90

There were differences across race/ethnicity with regard to representation in the *lowest quartile*.

Latino, Asian/Pacific Islander, and race-not-reported children were more likely to fall into the *lowest quartile*. Non-English speakers were more likely to fall into the *lowest quartile*.

Children without a personal physician, who reported problems getting care or who reported incidents of foregone care were more likely to fall into the *lowest quartile*.

While children with a chronic health condition were more likely to fall in the *lowest quartile*, more than half of the children in the *lowest quartile* did not indicate the presence of a chronic health condition. This is important because it illustrates that PedsQL™ scores are not merely a proxy for chronic health condition status.

III – Year 1 - Changes in health status based on enrollment in the Healthy Families Program.

Focus on Children with the Poorest Health Status Profile – Lowest Quartile

As discussed in the prior section describing the baseline study, on average, children entering the Healthy Families Program were considered healthy. We would expect that healthy children who continued enrollment in the Healthy Families Program over the one year period would remain healthy. This assumption was confirmed as overall Total PedsQL™ 4.0 scores remained the same from baseline (81.38) to year 1 (81.32).

With this in mind, the majority of the expected change in health status would be in the lowest quartile, or those children who had the lowest scores in the baseline year. These were the children defined as having the lowest health-related quality of life.

Given this premise, the research team concentrated on the children in the *lowest quartile* -- or those in the greatest need of the comprehensive medical, dental and vision services offered by the Healthy Families Program. A comparison of the baseline to year 1 presents the changes in health-related quality of life for the children in the *lowest quartile.*

Reaching these *lowest quartile* children with improved access and quality of service is a major objective of the Healthy Families Program.

How do children in the *lowest quartile* progress after a year of Healthy Families Program insurance coverage?

For children in the *lowest quartile*, PedsQL™ Total, Psychosocial and Physical scores showed remarkable improvements from the baseline to year 1. Table 9 shows the differences in reported scores for the *lowest quartile.*

Table 9. PedsQL™ Total and Summary Scale mean (standard deviation) scores in lowest quartile for PedsQL™ from baseline to year 1

PedsQL™ (N=1459)	Baseline Lowest Quartile	Year 1	Change
Total	58.09	71.73	13.64
Standard Deviation	(9.6)	(17.0)	
Physical	55.16	72.10	16.94
Standard Deviation	(18.2)	(22.4)	
Psychosocial	59.67	71.18	11.51
Standard Deviation	(10.8)	(16.8)	

The increases in scores were 13.64 points for the PedsQL™ Total scale, 16.94 points for the Physical Functioning scale and 11.5 points for the Psychosocial Summary scale.

As described earlier, if a child's score falls one standard deviation below the mean, monitoring and possible medical intervention should be considered, while scores two standard deviations below the mean require immediate medical intervention.

Scores for children who scored two standard deviations below the mean at baseline (those who required immediate medical attention) showed exceptional gains in health related quality of life. Total, Physical and Psychosocial scores are shown in Table 10.

Table 10. PedsQL Total and Summary Scale means (standard deviations) from baseline to year 1 for children greater than 2 standard deviations below the mean at baseline

PedsQL™ 4.0 n = 263	Baseline	Year One
Total	42.60	66.30
Standard Deviation	(6.19)	(20.19)
Physical	36.06	65.91
Standard Deviation	(12.28)	(25.77)
Psychosocial	46.39	66.12
Standard Deviation	(9.65)	(19.35)

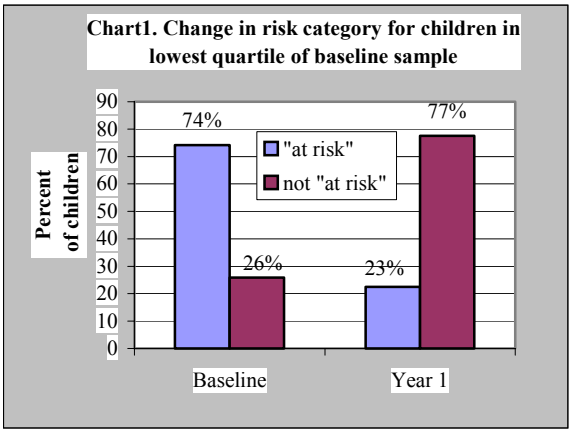
Gains of 24 points (+55%) in total scores were registered from baseline to time 1. Physical scores almost doubled (+83%), while psychosocial scores improved by 20 points (+43%).

This finding reinforces the positive role the Healthy Families Program has played in improving the health status of our most vulnerable subscribers.

Improvements in health- related quality of life through shifting 'at- risk' status

Another way to describe the improvement in health for children in the *lowest quartile* is to examine changes in 'at-risk' status. As described in the baseline analysis, 'at-risk' status is defined as PedsQL™ 4.0 Total Scale score at or below one standard deviation below the mean of the population.

The figures in Chart 1 show for children in the *lowest quartile*, the percent of children in the at-risk category at baseline and year 1. As can be seen, the majority of children in the *lowest quartile* shift from the 'at-risk' category to the 'not at-risk' category, essentially a shift from 75% 'at-risk' at baseline to 25% 'at-risk' status at year 1.



How did the Healthy Families Program influence access to care?

The Healthy Families Program improved access to care for children in the *lowest quartile* and for all children in the program.

Table 11 on the next page shows that both groups of children were more likely from baseline to year 1, to report having a regular physician and less likely to report problems getting care or foregone health care.

From baseline *to* year 1, *lowest quartile* children with a personal physician improved by **9.2** percent, problems getting care decreased by **6.0** percent and families foregoing needed care dropped by **10.1** percent. Similar improvement can also be seen in the entire sample.

Table 11. Percent of children with personal physician reporting problems getting care and reporting foregone care

	Baseline	Time1
Personal Physician		
Lowest Quartile	52.4%	61.6%
Highest Three Quartiles	58.4%	69.0%
Entire Sample	56.5%	67.2%
Problems getting care		
Lowest Quartile	29.0%	23.0%
Highest Three Quartiles	18.4%	15.7%
Entire Sample	19.1%	17.0%
Foregone health care		
Lowest Quartile	25.0%	14.9%
Highest Three Quartiles	15.3%	7.5%
Entire Sample	16.7%	9.2%

Improved access to care related to increases in PedsQL™ scores

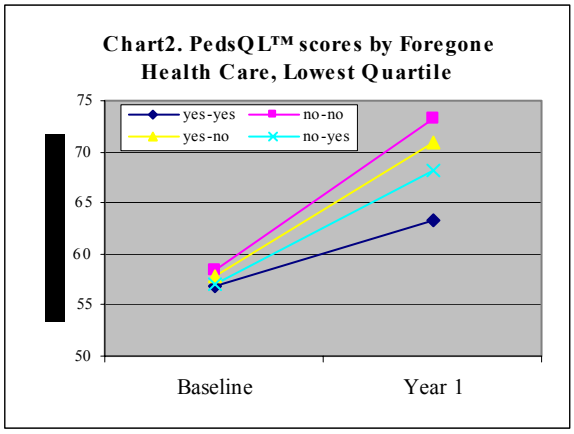
Changes in PedsQL™ scores in relation to reports of foregone health care were examined. Foregone health care is when parents report that there was a time in the last 12 months when they thought that their child needed medical care but they were unable to get it. Children in the *lowest quartile* were delineated into four (4) groups:

1. Children with foregone care at baseline and year 1 (yes-yes).
2. Children with no foregone care at baseline and year 1 (no-no).
3. Children with foregone care at baseline, but not year 1 (yes-no).
4. Children with foregone care at year 1, but not at baseline (no-yes)

As shown in Chart 2, this indicator of not getting necessary care was related to the rate of increase in PedsQL™ scores.

Specifically, while all four groups of children had increased PedsQL™ scores, children with:

- Persistent foregone care (yes-yes) had the smallest rate of increase.
- Children who had recent foregone care (no-yes) had an intermediate rate of increase.
- Children with consistent good access (no-no) or with improved access (yes-no) had the greatest rate of increase.



How did the Healthy Families Program influence chronic conditions?

Going back to Table 8 on page 5, not all children in the *lowest quartile* were those with chronic health conditions, and many children with chronic health conditions fell in the top three quartiles of PedsQL™ scores.

This means that to identify children who are not doing well, it is necessary to know more than whether the child has a chronic health condition.

Examining chronically ill children in the *lowest quartile* group shows these children's scores improved significantly from baseline to year 1.

Table 12 compares PedsQL™ scores for children in the *lowest quartile* with and without a chronic health condition.

Children without a chronic health condition had greater increases in PedsQL™ Total, Physical and Psychosocial scores than children with a chronic health condition.

Table 12. PedsQL™ Total and Summary Scale scores in the lowest quartile Baseline to Year 1 for children with and without chronic health conditions

PedsQL™ Scores	Baseline	Year 1	Change
Total			
Chronically Ill	57.86	65.93	8.06
Not Chronically Ill	58.26	72.84	14.58
Physical			
Chronically Ill	60.58	68.78	8.20
Not Chronically Ill	54.53	72.79	18.26
Psychosocial			
Chronically Ill	56.77	64.34	7.58
Not Chronically Ill	60.24	72.49	12.25

How did the Healthy Families Program influence psychosocial factors?

For children in the *lowest quartile*, PedsQL™ Emotional, School and Social Functioning scores improved from baseline to year 1. These results are shown in Table 13.

Table 13. PedsQL™ Emotional, School and Social Functioning Subscales mean scores in lowest quartile baseline to year1

PedsQL	Baseline	Year 1
Emotional	66.02	72.06
School	55.43	68.59
Social	56.65	71.78

How did the Healthy Families Program influence school performance?

Table 14 presents a detailed breakdown of the school functioning subscale from baseline to year 1 for children in the *lowest quartile*.

Table 14. PedsQL™ School Functioning Subscale item means) at baseline and year 1, for lowest quartile

Subscale Component	Baseline	Year1	Change
Paying attention in class	34.14	57.40	**23.26**
Forgetting things	60.21	68.85	8.65
Keeping up in school activities	36.28	60.89	**24.61**
Missing school because of not feeling well	73.15	77.38	4.22
Missing school to go to the doctor or hospital	72.21	77.12	4.91

As shown, the components most directly correlated to school performance improved by almost 70 percent, ("Paying attention in class" (68%) and "Keeping up with school activities" (68%)). Scores directly related to school and health also improved, but less remarkably.

Did scores differ between race and ethnic groups?

Table 15 shows that within the *lowest quartile*, PedsQL™ scores increased significantly for Latino, Asian/Pacific Islanders and Whites. The limited numbers of responses received from baseline and year 1 for African-American and American Indian make data for these two groups not statistically meaningful.

Table 15. PedsQL™ Total Scale means (standard deviations),from Baseline to Year1, by race/ethnicity

PedsQL™	Baseline	Year 1
Parent Proxy-Report		
White	60.42	69.31
Standard Deviation	(9.62)	(16.61)
Latino	57.42	71.96
Standard Deviation	(9.82)	(17.17)
Asian/Pacific Islander	59.74	73.32
Standard Deviation	(8.56)	(16.55)
Black/African American	Not Reported	
American Indian	Not Reported	

Summary of Key Findings

- **The Healthy Families Program meaningfully improved the health-related quality of life for children in the greatest need.**
  - Most children entering the Healthy Families Program were considered healthy. With this in mind, the majority of the expected change in health status would be in the *lowest quartile*, or those children who had the lowest scores in the base year.
  - Children in the poorest health (*lowest quartile*), as measured through the year one survey results, showed significant improvements in both physical psychosocial and composite health-related quality of life.
  - PedsQL™ scores for this *lowest quartile* increased **25** percent, from **58** to **72**, within the one year period of enrollment.
- **The Healthy Families Program had a positive impact on children with chronic health conditions.**
  - The greatest improvements were exhibited by children with a chronic health condition in the *lowest quartile*, with Total PedsQL™ scores improving from **58** to **66** from baseline *to* year 1.
- **Meaningful improvements in health-related quality of life were achieved within ethnic demographics.**
  - Results comparing the same groups after one year of enrollment indicate the scores for the *lowest quartile* improved "across-the–board".
- **The Healthy Families Program improved access to care for its members.**
  - Improved access to care has a positive correlation to improved health-related quality of life as measured through the PedsQL™ 4.0.
  - From baseline *to* year 1, children with a personal physician improved by **9 percent**, problems getting care decreased by **6 percent** and families foregoing needed care dropped by **10 percent**.
  - In the year prior to enrolling in the HFP, approximately **20 percent** of the families identified a problem in receiving needed care for their child. Children identified with a chronic condition were twice as likely to experience an access problem.
- **Children in the poorest health missed less school and improved school performance due to enrollment in the Healthy Families Program.**
  - PedsQL™ Total school functioning sub-scale scores increased by 24 percent, with remarkable improvements in scores related to "paying attention in class" and "keeping up with school activities".
- **Families participating in the Healthy Families Program are excited about the program and are willing to participate**
  - Of the 10,241 members surveyed during their initial month of enrollment, 6,881 (67%) remained in the HFP. ***Of these 6,881, more than 87% (6,005) completed the second year survey.***

Acknowledgments

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Appendix A – Detailed Description of the PedsQL™ Survey Instrument

PedsQL™ (Pediatric Quality of Life Inventory™) Outcome Measure

The health-related quality of life outcome measure is the PedsQL™ 4.0 Generic Core Scales. The PedsQL™ 4.0 Generic Core Scales include child self-report for ages 5-18 and parent proxy-report for children ages 2-18, and measure the core health dimensions (physical, psychological and social functioning) as delineated by the World Health Organization, as well as role (school) functioning. The PedsQL™ 4.0 Generic Core Scales have been shown to distinguish healthy children and pediatric patients with acute or chronic health conditions, and are related to indicators of morbidity and illness burden.

Previous research and evaluation projects with the PedsQL™ 4.0 have demonstrated a consistent difference between healthy children and children with chronic health conditions, such as asthma, arthritis, cancer, diabetes and cardiac conditions (Varni, Seid, & Kurtin, 2001; Varni, Burwinkle, Katz, Meeske & Dickinson, 2001). Healthy children have been shown to have significantly higher PedsQL™ 4.0 scores than children with chronic health conditions.

The PedsQL™ 4.0 has also been shown to be responsive to interventions of known efficacy, to be sensitive to different levels of disease severity and to have an impact on clinical decision making for pediatric chronic health conditions (Varni, Seid, Knight, Uzark & Szer, in press). Higher PedsQL™ 4.0 scores have also been shown to be positively related to parent report of their children's health care quality.

Design and Calculation of the PedsQL™ 4.0 Generic Core Scales Outcome Measure

The PedsQL™ 4.0 questionnaire encompasses four Scales: 1) Physical Functioning (8 items), 2) Emotional Functioning (5 items), 3) Social Functioning (5 items), and 4) School Functioning (5 items). The PedsQL™ 4.0 questionnaires are comprised of parallel child self-report and parent proxy-report formats. Child self-reports are administered to young children (ages 5-7), children (ages 8-12), and adolescents (ages 13-18). Parent proxy-reports are administered to parents of children ages 2-4 (toddler), 5-7 (young child), 8-12 (child), and 13-18 (adolescent). The parent proxy-report forms are parallel to the child self-report forms and are designed to assess the parent's perceptions of their child's health-related quality of life. The items for each of the forms are essentially identical, differing only in developmentally appropriate language or first or third person tense.

The survey instructions ask how much of a problem each item has been during the past one month. A 5-point response scale is utilized (0 = never a problem; 1 = almost never a problem; 2 = sometimes a problem; 3 = often a problem; 4 = almost always a problem). Items are reverse-scored and linearly transformed to a 0-100 scale (0 = 100, 1 = 75, 2 = 50, 3 = 25, 4 = 0). Higher scores indicate better health-related quality of life. To create the Total Scale Score (all 23 items), the mean is computed as the sum of the item responses divided by the number of items answered in the Physical, Emotional, Social and School Functioning sub-scales. To create the Psychosocial Health Summary Score (15 items), the mean is computed as the sum of the item responses divided by the number of items answered in the Emotional, Social and School Functioning sub-scales.

ATTACHMENT 5

2002 Open Enrollment Report

Open Enrollment 2002 Summary Report

Total Subscribers with option to change plans at 2002 OE **555,890**	Subscribers Who Voluntarily Changed Plans	% of Total	Subscribers Who Were Required to Change Plans	% of Total	Sub-Total Subscribers That Changed During OE	% of Total	Total Subscribers That Changed During OE	% of Total
Total Subscribers changing Health Plans:	**8,347**	**1.50%**	**5,318**	**0.96%**	**13,665**	**2.46%**	**16,485**	**3%**
Total Subscribers changing Dental Plans:	**8,546**	**1.54%**	**776**	**0.14%**	**9,322**	**1.68%**	**12,142**	**2%**
Total Subscribers changing both Health and Dental Plans:	**2,203**	**0.40%**	**617**	**0.11%**	**2,820**	**0.51%**		

Open Enrollment Historical Data

	1999		2000		2001		2002	
Total Subscribers Changing Health Plans	3,827	3%	10,326	4%	14,566	3%	16,485	3%
Total Subscribers Changing Dental Plans	3,875	3%	8,005	3%	22,031	5%	12,142	2%
Total Subscribers With Option To Change Plans at OE	113,083		293,978		434,346		555,890	

Data includes voluntary and required transfer requests

Open Enrollment 2002 - Satisfaction Survey

- Over 4,500 responses were received to the Satisfaction Survey

On a scale of 1 – 5 (5 meaning extremely satisfied; 1 meaning not satisfied at all) on average respondents indicated they were *Satisfied* with the services received from their Health Plan (3.0) and Vision Plan (3.7) but *Not Very Satisfied* with the services received from their Dental Plan (2.3).

Reasons Why Plan Transfers Were Requested

- 5,899 responded to Health Plan survey and 6,096 responded to Dental Plan survey

Top Reasons

Health Plan Changes

1. Problem getting a Doctor I'm happy with
2. Not being able to see a doctor when the need is urgent
3. Appointments to see the doctor have to be made too long in advance

Dental Plan Changes

1. Problem getting a Dentist I'm happy with
2. Appointments to see the dentist have to be made too long in advance
3. Not satisfied with the dental care received

HEALTHY FAMILIES

Customer Satifaction Survey Historical Data

Open Enrollment 1999-2002

Survey Question	Response	Extremely Satisfied (5)	Very Satisfied (4)	Satisfied (3)	Not Very Satisfied (2)	Not at all (1)	Average Score
"How satisfied are you with the level of service you have received from your Health Plan?"							
1999	*	*	*	*	*	*	2.3
2000	*	*	*	*	*	*	3.4
2001	4780	*	*	*	*	*	3.0
2002	4742	569 (12%)	863 (18%)	1683 (35%)	1212 (26%)	415 (9%)	3.0
"How satisfied are you with the level of service you have received from your medical group/clinic and the doctors and nurses who work there?"							
1999	*	*	*	*	*	*	2.3
2000	*	*	*	*	*	*	3.4
2001	4559	*	*	*	*	*	3.1
2002	4584	671 (15%)	871(19%)	1598 (35%)	1010 (22%)	434 (9%)	3.1
"How satisfied are you with the level of service you have received from your Dental Plan?"							
1999	*	*	*	*	*	*	1.5
2000	*	*	*	*	*	*	3.0
2001	6895	*	*	*	*	*	2.2
2002	4683	299 (6%)	384 (8%)	1045 (22%)	1603 (34%)	1352 (29%)	2.3
"How satisfied are you with the level of service you have received from your Vision Plan?"							
1999	Question Not Included On Survey						
2000	Question Not Included On Survey						
2001	7973	*	*	*	*	*	3.7
2002	9743	2857 (29%)	2800 (29%)	3526 (36%)	368 (4%)	192 (2%)	3.7

Legend
*** Data is not available**
1999 data included voluntary and required transfer requests
2000 data included voluntary and required transfer requests
2001 data included voluntary transfer requests only (except Vision Question)
2002 data included voluntary transfer requests only (except Vision Question)

Health Plan Change Reasons Historical Data

Open Enrollment 1999-2002

Note - Applicant may have indicated more than one reason. Data includes voluntary transfer requests.

	1999		2000		2001		2002	
Surveys Returned each OE Year	641		3,160		6,400		5,899	
Responses for each OE Year	494		3,586		7,413		11,457	
Reason	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**
Problem getting a Doctor I'm happy with	*125	25%	*719	20%	987	13%	1555	14%
Problem getting a specialist when I need one	*36	7%	*279	8%	520	7%	923	8%
Problem getting care that I or my doctor believed to be necessary	**	**	**	**	357	5%	604	5%
Not satisfied with medical care received	*75	15%	*719	20%	716	10%	1090	10%
Primary care doctor left the plan	63	13%	201	6%	403	5%	610	5%
Appointments to see the doctor have to be made too long in advance	63	13%	591	16%	651	9%	1153	10%
Not being able to see a doctor when the need is urgent	**	**	**	**	723	10%	1191	10%
Not satisfied with the hours or days a primary care doctor's office is open	*18	4%	*382	11%	350	5%	479	4%
Problem getting help or advise during regular office hours	**	**	**	**	358	5%	616	5%
I need an interpreter but doctor's office does not have one	*29	6%	*124	3%	120	2%	172	2%
Doctor's office is too far away. Check one:	67	14%	440	12%	507	7%	707	6%
1 to 5 miles	**	**	**	**	74	1%	81	1%
6 to 10 miles	**	**	**	**	136	2%	210	2%
10 miles or more	**	**	**	**	293	4%	416	4%
Children are discriminated against because they are enrolled in Healthy Families.	18	4%	131	4%	132	2%	204	2%
Other:	**	**	**	**	1086	15%	1,446	13%
Total	494	100%	3,586	100%	7,413	100%	11,457	100%

Legend

* The wording of the question has changed. The meaning is generally the same.

** The question was not included in that year's survey.

Dental Plan Change Reasons Historical Data

Open Enrollment 1999-2002

Note - Applicant may have indicated more than one reason. Data includes voluntary transfer requests.

	1999		2000		2001		2002	
Surveys Returned each OE Year	740		2949		7587		6096	
Responses for each OE Year	473		1,737		15,985		13,338	
Reason	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**	**Number of Responses**	**% of Cases**
Problem getting a dentist I'm happy with	*233	49%	*757	44%	2343	15%	2031	15%
Problem getting a specialty dentist when I need one	*77	16%	*362	21%	1083	7%	948	7%
Problem getting care that I or my dentist believed to be necessary	**	**	**	**	669	4%	625	5%
Not satisfied with dental care received	163	34%	*618	36%	1624	10%	1,469	11%
Primary care dentist left the plan	**	**	**	**	634	4%	457	3%
Appointments to see the dentist have to be made too long in advance	**	**	**	**	1917	12%	1,679	13%
Not being able to see a dentist when the need is urgent	**	**	**	**	1324	8%	973	7%
Not satisfied with the hours or days a primary care dentist's office is open	**	**	**	**	587	4%	512	4%
Problem getting help or advise during regular office hours	**	**	**	**	478	3%	477	4%
I need an interpreter but dentist's office does not have one	**	**	**	**	343	2%	268	2%
Dentist's office is too far away. Check one:	**	**	**	**	1408	9%	1106	8%
1 to 5 miles	**	**	**	**	121	1%	103	1%
6 to 10 miles	**	**	**	**	385	2%	281	2%
10 miles or more	**	**	**	**	886	6%	684	5%
Children are discriminated against because they are enrolled in Healthy Families.	**	**	**	**	342	2%	373	3%
Other:	**	**	**	**	1841	12%	1352	10%
Total	473	100%	1,737	100%	15,985	100%	13,338	100%

Legend

* The wording of the question has changed. The meaning is generally the same.

** The question was not included in that year's survey.

ATTACHMENT 6

2000/2001 Copayment Report

2000/2001 Copayment Report

During the 2000-2001 benefit year, **235** families enrolled in the Healthy Families Program (HFP) paid the maximum annual health benefit copayment amount of $250. This represents less than one tenth of one percent (.079%) of the total number of HFP families enrolled during the 2000/2001 benefit year.

INTRODUCTION AND BACKGROUND

The design of the HFP benefits package requires subscribers to pay $5 copayments for certain benefits at the time services are provided. Health services that require copayments include physician office visits, prescription drugs, outpatient mental health and substance abuse services, acupuncture, chiropractic and biofeedback services. Dental services that require copayments include major procedures such as root canals, crowns and bridges. Vision services (eye examinations and prescription glasses) require copayments.

There are many benefits that are provided which do not require copayments. These health and dental services include:

- Preventative health services, immunizations
- Inpatient care
- Preventative dental care
- Restorative dental procedures (fillings and x-rays)

Federal law limits the out-of-pocket expenses that may be charged to families to no more than 5 percent of household income for families above 150% of the federal poverty level (fpl). For families with household incomes up to 150% fpl, out-of-pocket expenses are limited to "reasonable amounts as approved by the Secretary of Health and Human Services". California Insurance Code, Section 12693.615 further restricts the amount of copayments to no more than $250 per year per family for health benefits.

Participating health plans report annually on the number of families who meet the $250 copayment maximum for the previous benefit year. Participating dental and vision plans are required to report the number of subscribers who pay copayments.

This report provides information on how many families reached the $250 annual maximum copayment during the July 1, 2000 to June 30, 2001 benefit year.

RESULTS FOR THE 2000/2001 BENEFIT YEAR

Enrollment

The total number of HFP subscribers enrolled at any time during the 2000/2001 benefit year was 569,817. These subscribers belonged to 298,567 families who were members of 26 health plans participating in the HFP.

Aggregate Findings

The total number of families reaching the $250 health benefit copayment limit was **235.** The total number of children in these families equaled **564.** Approximately **.079%** of families met the maximum HFP copayment requirement during the 2000/2001 benefit year.

Results by Health Plan

Of the 26 participating health plans, eight had at least one family who reached the maximum $250 dollar limit, while 18 health plans had no subscribers reaching the copayment limit.

Trends

In the 1999/2000 benefit year **.035%** of all families reached the copayment maximum. While the 2000/2001 level of .**079%** remains less than one tenth of 1 percent, it represents a doubling on the 1999/2000 rate.

Plan Name	Number of Families Reaching $250 Health Copayment Maximum	Number of Children Within Families Reaching $250 Copayment Maximum
Kaiser Permanente	174	424
Blue Shield HMO	39	82
Kern Health Systems	6	17
Blue Cross HMO	6	11
Ventura County Health Care	5	18
Alameda Alliance for Health	2	7
Health Plan of San Joaquin	2	3
Inland Empire Health Plan	1	2

ANALYSIS AND COMPARISIONS

Health, dental and vision plan copayment data was linked with demographic data from the HFP enrollment database. MRMIB generated demographic views for all children and families who reached the $250 copayment maximum.

Family Income

Of the **235** families that reached the $250 copayment maximum, **75** families incurred vision copayments, **12** families incurred dental copayments and **4** families incurred both dental and vision copayments. The following table provides the income profile of the *average family who reached the $250 health copayment limit* and paid a dental and/or vision copayment during the 2000/2001 benefit year.

Profile of Families Reaching $250 Maximum Copayment

Category	Number of Families	Average Annual Income	Average Total HFP Premiums plus Copayments	% of Annual Income
	235	**$32,123**	**$424**	**1.32%**
Incurred Vision Copayments	75	$33,037	$448	1.36%
Incurred Dental Copayments	12	$34,302	$480	1.40%
Incurred Dental and Vision Copayments	4	$35,460	$491	1.38%

The average number of children was 2.8 and the average family size was 4.2 for those families reaching the $250 copayment maximum.

Families reaching the $250 copayment maximum increased from **49** in benefit year 1999/2000 to **235** in benefit year 2000/2001. The majority of the change occurred in the Kaiser Permanente health plan (29 to 174).

Of the 235 families who reached the copayment maximum, total out-of-pocket expenditures *increased* by $25 over benefit year 1999/2000, while average incomes increased by $633. Average out-of-pocket expense as a percent of household income was **1.32%** compared to **1.27%** in the 1999/2000 benefit year. These figures provide validation for the federal "reasonableness" requirement.

Of the 235 families, 36 percent were at or below 150% (fpl) 38 percent between 150% and 200% (fpl) and 26 percent above 200% (fpl).

Ethnicity and Primary Language

The tables below compare ethnicity and language characteristics of the 235 families who met the $250 annual copayment limit to those of the overall HFP population during 2000/2001 benefit year.

Ethnicity

Ethnicity	Families at $250	HFP Population
Latino	43%	67%
White	27%	15%
Asian/Pacific Islander	17%	13%
African American	4%	3%
Other	7%	2%

Primary Language of the Applicant

Language	Families at $250	HFP Population
English	67%	50%
Spanish	26%	40%
Asian (Chinese, Korean, Vietnamese)	4%	8%
Other	3%	2%

CONCLUSION

The copayment requirements of HFP families are within the range of out-of-pocket expenses required by federal law. No family with a household income between 150% - 200% fpl paid at or over 5% of income for health insurance copayments. For families that reached the $250 annual copayment limit with household incomes below 150% fpl, out-of-pocket expenses for premiums and copayments averaged less than **1.5%** of income.

ATTACHMENT 7

Crowd-Out in the Healthy Families Program: Does it Exist?
University of California, San Francisco Study

Crowd-Out in the Healthy Families Program:

Does it Exist?

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EXECUTIVE SUMMARY

Researchers from the University of California, San Francisco undertook a study of children's coverage prior to enrollment in Healthy Families. Children with employer-related insurance within 3 months prior to enrolling in the program are ineligible, as a means to discourage employers and families from supplanting private insurance with public insurance. This research was designed to determine the extent to which this phenomenon, called "crowd-out," exists within the Healthy Families program.

Telephone interviews were conducted between April 10 - April 24, 2002 of 57 Spanish-speaking and 468 English-speaking parents and guardians of children newly enrolled in the Healthy Families program. The major findings of this study are:

- Some crowd-out is occurring, but at very low levels (8%);

- When crowd-out does occur, it tends to happen among lower income families and is largely because parents can no longer afford the employment-related coverage for their children. In fact, nearly half (45%) of the families reported that they had been paying more than $50 per month for their child's employment-related coverage;

- Based on this survey, it does not appear that employers are encouraging children to drop coverage and enroll in the Healthy Families Program. None of the respondents indicated that this occurred; and

- The coverage status of parents indicates that children were dropped from employment-related coverage, but parents tend to retain their own employment-related coverage.

RECOMMENDATIONS

These findings suggest that public policy in California should not focus on crowd-out as a phenomenon that affects eligibility for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs. Among the policy options is providing assistance to low-income families in their ability to purchase and maintain employment-related insurance. The state could also explore once more the feasibility of implementing the provision in the law establishing the Healthy Families Program, which permits employers to provide premium support for their employees' dependents. Another (though not mutually exclusive) option is the imposition of a financial test with respect to determining if crowd-out occurs. That is, eligibility for publicly subsidized programs should take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows "substitution" (or, in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income.

INTRODUCTION

In response to the lack of health coverage in the United States, Congress enacted the Balanced Budget Act of 1997, which amended the Social Security Act to include Title XXI, the State Children's Health Insurance Program (SCHIP). The goal of SCHIP is to increase access to health care for children whose family incomes are too high to qualify for Medicaid and too low to afford private coverage. The program provides approximately $40 billion in matching funds to states over ten years; California's total SCHIP allotment for the Healthy Families Program amounts to $4.5 billion.

There is concern among some policymakers and program planners that the creation and expansion of publicly subsidized programs may supplant and "crowd-out" private, employment-related insurance, rather than cover uninsured individuals. Concern about crowd-out originally emerged in the early and mid-1990s when policymakers and researchers examining trends in health insurance coverage noted that as Medicaid enrollment rose during the 1980's and 1990's the number and percentage of children covered under private insurance plans declined. This led to speculation that the Medicaid expansions for children may not have extended coverage to previously uninsured children, but rather covered children who already had private insurance.

To date, some research has been conducted on the presence of crowd-out, but the results have been mixed. In a study using data from the Current Population Survey (CPS), Cutler and Gruber found that nearly half of the increase in Medicaid enrollment was offset by a decrease in private insurance coverage.[1] On the other hand, other studies using the same data report significantly less crowd-out. Dubay and Kenney found a crowd-out effect of 12% for children under 11 years of age, and 14% for pregnant women.[2] Determining the presence and extent of crowd-out is an important policy matter because it has been used extensively in arguments against the expansion of publicly funded health insurance programs. For example, at the national level, crowd-out was a major argument against the establishment of SCHIP, which led to the creation of Healthy Families in California.[3]

Researchers from the University of California, San Francisco undertook a study of families' coverage prior to their child's enrollment in Healthy Families. In California, children with employment-related insurance within 3 months of applying for Healthy Families coverage are not eligible. This study was conducted to determine the extent to which crowd-out exists within Healthy Families as well as help to demonstrate California's commitment to rigorous monitoring of the issue.

METHODOLOGY

Sample Selection

The Managed Risk Medical Insurance Board (MRMIB), the agency that administers Healthy Families, provided the contact data based on a random sample of 3,000 recent enrollees (i.e., children who enrolled within 60 days of the date the sample was drawn). MRMIB provided names and contact information for 1,500 enrollees at or above 200 percent of the poverty level, and 1,500 enrollees below

the poverty level. (This reflects an over-sampling of the higher income group to ensure that they were adequately represented in the final sample.) Only English- and Spanish-speakers were interviewed. The sample was reduced by excluding those whose Healthy Families coverage began more than two months before the data pull, enrollees who did not have phone numbers, duplicates from households (based on a sort of parents' names and addresses) and individuals who indicated that they did not want to be called (by returning a self-addressed, stamped post card sent to each potential subject for this purpose). The final sample-frame included 1,958 enrollees at or above 200 percent of poverty and 1,042 enrollees below 200 percent of poverty.

Data Collection

Parents and guardians of enrolled children were contacted initially by mail to inform them about the study and to request their participation. The mailing, written in both English and Spanish, included a letter of introduction, a study information sheet, and a self-addressed, stamped postcard that individuals could return if they did not want to participate in the study. In addition, a $10 incentive was promised to those respondents who completed the telephone interview and was subsequently mailed to the respondents).

A telephone survey instrument was developed to assess the extent and nature of crowd-out among newly enrolled participants in California's Healthy Families Program. The instrument was based on validated surveys designed to elicit similar information, and on the feedback from program administrators to ensure inclusion of pertinent policy and program questions. Corey, Canapary, and Galanis Research (CC&G), a San Francisco survey research firm, phoned parents and guardians to request their consent to participate in the study and conduct the interview. English-speaking interviewers made all initial calls on the randomly drawn sample. Interviews were conducted with qualified respondents if possible. This includes respondents who spoke English well enough to do the interview. If a Spanish-speaking respondent was unable to do the interview in English, he/she was called back by a bilingual (Spanish/English) interviewer. CC&G conducted the telephone survey using a computer assisted telephone interview (CATI) format. Telephone calls were made 3 weeks after the letters were mailed to potential participants. The sample of individuals randomly selected to be called was 783. In total, 525 interviews were completed. This represents an overall completion rate of 67% (525 divided by 783). The (See Tables 5 and 6 in the appendix.)

RESULTS

Characteristics of Enrollees

Of the total 525 interviews with families who participated in the survey, 468 were in English and 57 interviews were conducted in Spanish. As Table 1 illustrates, the majority of the children in the sample are Hispanic (63%), while whites comprise the next largest group at 25%. Asians and African

Americans each make up 4% of the total sample, and the remaining 3% belong to other ethnic groups. This distribution is somewhat different than that of current Healthy Families enrollees. (Sixty-seven percent of current enrollees are Latino, 16% are White, 13% are Asian, 3% are African American and less than 1% are of other ethnicities.) Sixty-four percent of interviewed families have one working adult in the household and a mean household income of $32,100. The average family size is four.

Table 1: Profile of Survey Participants

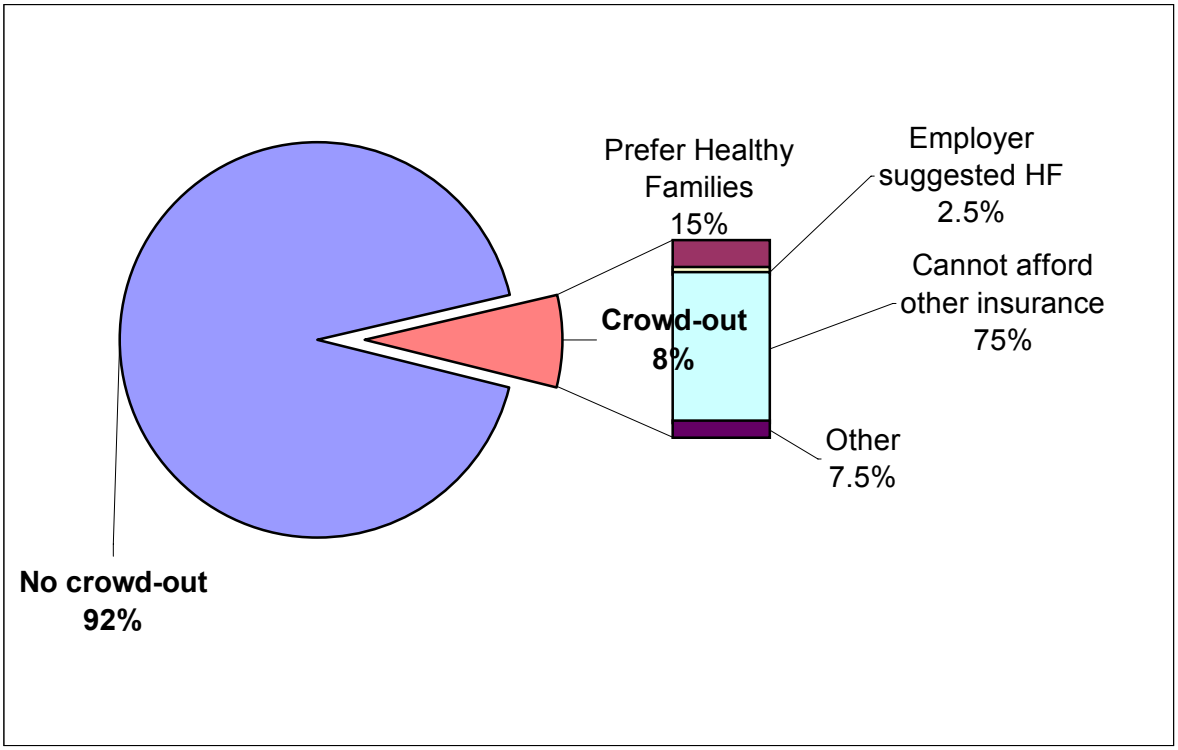
Demographic Characteristics	All Respondents		English-Speaking Respondents		Spanish-Speaking Respondents	
	Number	Percent (n=525)	Number	Percent (n=525)	Number	Percent (n=525)
Total	525	100%	468	89%	57	11%
Race/Ethnicity						
Hispanic/Latino	332	63.2%	275	52%	57	11%
White	132	25.1%	132	25%	0	0%
Asian	22	4.2%	22	5%	0	0%
African American	22	4.2%	22	5%	0	0%
Other	17	3.2%	17	4%	0	0%
Family Income						
100-199% FPL	363	69%	320	61%	43	8%
200-250% FPL	162	31%	148	28%	14	3%
Household Type						
Single parent	125	24%	121	23%	4	1%
Dual parent	400	76%	347	66%	53	10%
Full- or Part-Time Employed Adults in Household						
None	29	6%	27	5%	2	0.4%
1	334	64%	301	57%	33	6%
2	162	30%	140	27%	22	4%
Family Size						
2	47	9%	45	9%	2	0.4%
3	138	26%	126	24%	12	2%
4	174	33%	157	30%	17	3%
5	108	21%	90	17%	18	3%
6 or more	58	11%	50	10%	8	2%

The Presence of Crowd-Out in Healthy Families

We estimate crowd-out in the Healthy Families Program to be 8%. (Figure 1) That is, only 8% of the sample had previous insurance within the three months prior to enrolling in Healthy Families and dropped that insurance for reasons that constitute crowd-out. These reasons include families who had access to employment-related coverage but dropped it because the employment coverage was unaffordable (n=30), who preferred Healthy Families (n=6), whose employer suggested enrollment in Healthy Families (n=1), and who dropped it for other reasons (n=3). (The percentage of children exhibiting crowd-out may actually be might be lower if the "other" category of reasons for dropping

previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them.) (See the appendix for demographic characteristics of the crowd-out group compared to the non-crowd-out group.)

Figure 1: Estimate of Crowd-Out in California's Healthy Families Program



Crowd-out represents a small portion of enrollment. When crowd-out occurs, it is because the family can no longer afford employer coverage.

Crowd-Out by Family Income

When considering family income, lower income children were more likely than higher income children to have had prior insurance that constitutes crowd-out. Specifically, 68% of all children exhibiting crowd-out had incomes between 100% and 199% of the federal poverty level. (Table 2) At first blush, this finding appears counterintuitive since children in higher incomes are more likely to have employment-related insurance. However, the most frequently cited reason for ending their employment-related insurance was that the family could not afford it (75%). Moreover, lower income parents were most likely to report not being able to afford the insurance (45% for lower income families versus 30% of higher income families.) This is corroborated by responses to a follow-up question of families who indicated they preferred Healthy Families. When asked why they preferred Healthy

Families, five of the six crowd-out families said they preferred it because the program is "less expensive." (Not shown.)

Table 2: Crowd-Out Related Reasons for Ending Employment-Related Insurance Coverage, 0-3 Months Prior to Enrollment in Healthy Families

Reasons for ending employment-related insurance coverage	Total		100% to 199% of FPL		200% to 250% of FPL	
	Number	Percent (n=40)	Number	Percent (n=40)	Number	Percent (n=40)
Prefer Healthy Families	6	15%	5	13%	1	2%
Employer suggested enrollment of child in Healthy Families	1	2%	1	2%	0	0%
Cannot afford other insurance	30	75%	18	45%	12	30%
Other	3	8%	3	8%	0	0%
Total	40	100%	27	68%	13	32%

Cost of Employment-related Coverage: Crowd-Out versus Non-Crowd-Out Groups

The cost of previous coverage among children exhibiting crowd-out varied greatly and ranged from less than $10 per month to more than $75. (Table 3) More than a quarter (27%) of the crowd-out group reported that they paid more than $75 per month for their child's coverage. Only 13% of the crowd-out group indicated that they paid $10 or less per month for previous coverage. These high costs among the crowd-out group likely explain that they dropped previous coverage because they couldn't afford it.

Table 3: Cost of Previous Coverage

Cost of Previous Coverage	Crowd-Out Group	
	Number	Percent (n=40)
$10 or less per month	5	13%
$11-$25 per month	1	3%
$26-$50 per month	7	17%
$51-$75 per month	7	18%
More than $75 per month	11	27%
Other	8	18%
Don't Know	1	3%
Total	40	100%

Parent's Insurance Status: Respondents (typically parents or guardians of enrolled children) were asked about their own insurance status. (Table 4) Of the 27 crowd-out parents with current insurance, 25 had private insurance through an employer or union. This suggests that parents of the crowd-out group of children may have dropped only dependent coverage and retained their own coverage.

Table 4: Respondent/Parents' Insurance Status

Respondent/Parents' Insurance Status	Crowd-Out	
	Number	Percent (N=40)
Currently insured	27	68%
Currently uninsured	12	30%
Don't know	1	2%
Total	40	100%

DISCUSSION AND RECOMMENDATIONS

This study was undertaken to determine the extent to which crowd-out, the substituting of employment-based health insurance with public health insurance – exists within the Healthy Families program. Based on survey responses of parents of newly enrolled children, we learned that there is some extent of crowd-out in the program: 8% of newly enrolled children had employment-related insurance within the previous three months that is not considered legitimate. (This figure might be actually lower if the "other" category of reasons for dropping previous health insurance is excluded from the numerator. However, because we cannot know with certainty whether or not these reasons fall within the definition of crowd-out, we included them to ensure the most conservative interpretation.) Other states have found varying degrees of employment-related insurance prior to enrollment in public programs. Eleven percent of children in Florida's Healthy Kids program[4] and 3.5% of respondents to a 1995 survey of the MinnesotaCare program indicated that they gave up employment-related insurance to enroll in the state program.[5] (Note that these analyses of the experiences in other states are not directly analogous to this analysis due to different definitions and different timeframes under study. In addition, the Minnesota program measured previous coverage among both adults and children.)

Although the findings from this study are within the range of Florida's experiences (and higher than that of Minnesota), several distinctions between the periods when the studies were conducted and the circumstances of the states are important to note. First, this study was conducted at a time when the California economy was on a steep decline with no concomitant reduction either in the high cost of living in the state for families or tough financial conditions for businesses. At the same time, the cost of

health care has increased, leading to higher premiums for families as well as reductions in dependent coverage provided by employers. In addition, this study's time frame covered the period in which most employees were given the opportunity to change their employment-related insurance plans through the end-of-year open enrollment period (a period when increases in employee contributions are introduced). Together, these factors may have contributed to employers dropping health insurance coverage and/or families electing to drop coverage, circumstances that were not present during the periods when the other studies were conducted.

More important, this study demonstrates that the unaffordability of previous health insurance was the single most important reason for crowd-out in the Healthy Families Program. Seventy five percent of the parents whose children had health insurance in the three months prior to enrollment in Healthy Families for reasons that constitute crowd-out reported that they dropped that prior coverage because it was unaffordable. This finding is further supported by the predominance of crowd-out among lower income families and the far higher costs of previous coverage among the crowd-out group. Of all parents whose children exhibited crowd-out, 68% were in this lower income group and 45% of these reported that they dropped previous coverage because they could not afford it. Further, nearly half (45%) of the crowd-out group paid more than $50 per month for their children's coverage under the previous coverage. These findings throw into question whether crowd-out really exists in California, even at low levels such as 8%. To the extent that the vast majority of these low income families dropped relatively expensive employment-related insurance and enrolled their children in Healthy Families for financial reasons, it is arguable that this is not crowd-out but a sound financial decision, affording families a degree of discretionary income to address other family needs. This suggests that public policy in California should not focus on crowd-out as a phenomenon that influences eligibility rules for public programs, but rather should identify ways to ensure that children have coverage, whether through employment-related approaches or public programs.

We recommend three policy options for the State of California (which are not mutually exclusive):

- Assist low-income families financially in purchasing and maintaining employment-related insurance;
- Explore the feasibility of implementing the voucher provision in the law establishing the Healthy Families Program that permits employers to obtain subsidized premium support for their employees' dependents; and
- Impose a financial test when determining if crowd-out occurs.

With this third option, eligibility for publicly subsidized programs would take into account not only whether or not a child recently had previous coverage, but also if that coverage was affordable to the family. Some states have already instituted such policies. For example, Georgia allows "substitution" (in other words, does not consider it crowd-out) if previous insurance coverage cost the family more than 5% of the family income. In this study, the proportion of annual premiums of prior employment-related insurance to annual incomes of parents suggests that no fewer than (and likely more than) 10% of the children in the crowd-out group would be permitted to substitute coverage if Georgia's criterion were applied to California. (Note that in this calculation, respondents' premium costs were calculated at the *lowest* amount in a range when respondents were unable to offer a specific cost per month. California would also need to take into account such factors as family size, number of children, and allowable deductions in this calculation, which would presumably decrease the number of children in the crowd-out group.)

California should consider these policy options given the apparent burden of high health care costs on low-income families – to the extent that it exists at all. Parents need options for health insurance coverage for their children and Healthy Families appears to be a reasonable option for low-income families. This is true even for the few families that previously had employment-related but expensive coverage and other financial demands on their relatively low income.

Appendix

Table 5: Crowd-Out Survey Fieldwork Information and Sample Disposition

Field interviewing for the 2002 Crowd-Out Survey was conducted by telephone from April 10 - April 24, 2002. All fieldwork was done at the offices of Corey, Canapary & Galanis Research (CC&G) in San Francisco. Interviewing was conducted in English and Spanish. In total, 525 interviews were completed with Healthy Family program enrollees. The sample of individuals randomly selected to be called was 783. This represents an overall completion rate of 67% (525 divided by 783). The table, which follows, details the disposition of the sample.

Sample Available

	Number
Total sample (names/numbers) provided by UCSF	3,000
Respondents who sent back postcards indicating they not be called for the project	-115
Total sample (names/numbers) available	2,885
Sample (names/numbers) attempted by CC&G	783

Table 6: Disposition of Sample by Language

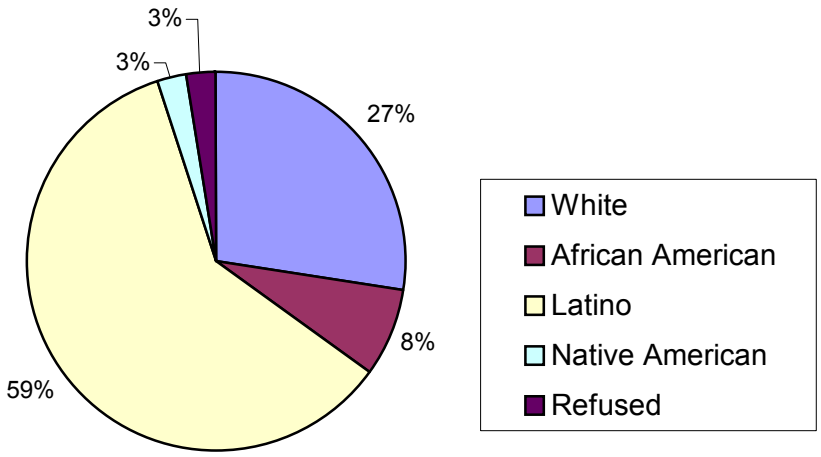
	English	Spanish	Total
Completed surveys	*468*	*57*	*525*
DISQUALIFIED			
Child not enrolled in Health Families	5	1	6
Child not enrolled in Healthy Families during study timeframe	2	1	3
No Eligible Respondent	21	5	26
Language Barrier	7	-	7
Fax Number	2	-	2
Answering Machine/No Answer/Busy	69	22	91
Not At Home/Call Back	15	11	26
Disconnected/Wrong Number	63	-	63
QUALIFIED			
Respondent terminated call	1	0	1
Respondent refused to participate	29	4	33
	682	101	783

**In most cases, these respondents were called at least 4 times.*

Characteristics of Families: Crowd-Out versus Non-Crowd-Out Groups

Race and Ethnicity: The vast majority of children in the crowd-out group identified as Latino (59%). (Figure 2) Another 27% were White, 8% African American and 3% Native American. This distribution is essentially equivalent to that of the group for which there was no evidence of crowd-out. (Not shown.)

Figure 2: Race and Ethnicity of Children in the Crowd-Out Group (n = 40)



Family Income: The distribution of income as a percentage of the Federal Poverty Level was largely equivalent between the two groups. (Table 7) Approximately two-thirds of each group had incomes between 100% and 199% of the poverty level and one-third had incomes between 200% and 250% of the poverty level.

Table 7: Income as a Percentage of the Federal Poverty Level

Income Level	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
100% to 199% of FPL	26	65%	335	69%
200% to 250% of FPL	14	35%	148	31%
Missing data	-	-	2	0%
Total	40	100%	485	100%

Parents' Employment Status: Generally equivalent proportions of parents had at least one parent who worked full time, though the crowd-out group was slightly more likely to have at least one parent employed full time. (Table 9)

Table 8: Parents' Employment Status

Employment Status	Crowd-Out		Non-Crowd-Out	
	Number	Percent (n=40)	Number	Percent (n=485)
At least one parent employed full time	34	85%	398	82%
1 parent employed part time	1	2%	35	7%
2 parents employed part time	0	0%	30	7%
No parent employed	5	13%	22	4%
Total	40	100%	485	100%

[1] Cutler D, and Gruber J. The Effect of Medicaid Expansions on Public Insurance, Private Insurance, and Redistribution. *American Economic Review.* Volume 86, No. 2. 1996.
[2] Dubay L, and Kenney G. Revisiting the Issues: The Effects of Medicaid Expansions on Insurance Coverage of Children. *The Future of Children.* Volume 6, No. 1. 1996.
[3] Hearne. Coordinating Children's Coverage Expansions with Employer-Sponsored Coverage. Washington, DC: Institute for Health Policy Solutions.
[4] Institute for Child Health Policy. Florida KidCare Program Evaluation Report. University of Florida. January 2000.
[5] Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? *JAMA.* 1997;278:1191-1195.

ATTACHMENT 8

2002 Consumer Assessment of Dental Plans Survey

2002 Consumer Survey of Dental Plans

In the Spring of 2002, the Managed Risk Medical Insurance Board (MRMIB), through a contract with an independent vendor (DataStat, Inc.), conducted a consumer survey of dental plans participating in the Healthy Families Program (HFP). The survey was the result of a collaboration among MRMIB staff, members of the CAHPS® consortium (Ron D. Hays, PhD., UCLA School of Medicine, Julie Brown, RAND, and James J. Crall, DDS, ScD, Columbia University) and DataStat, Inc. an independent survey vendor under contract with MRMIB. This survey was the first consumer survey of dental plans using the instrument developed by members of the CAHPS® consortium.

The survey was conducted to assess the satisfaction and experience families were having with participating dental plans and to provide existing and potential HFP applicants with information about their dental plan options. This report summarizes the results from the survey.

SURVEY METHODOLOGY

The instrument used for the survey was developed by the CAHPS consortium and modified for the Healthy Families Program. The instrument was based on the Child Medicaid version of the Consumer Assessment of Health Plan Survey (CAHPS) 2.0H which contains 70 questions pertaining to nine aspects of care. The aspects of care that were covered in the survey include access to care, customer service, communication of providers, and quality and satisfaction of dental plan services and dental care received. The responses to the survey questions were summarized into four global ratings and five composite scores. The global ratings included ratings of dental care, dental plan, regular dentists and specialists. The composite scores addressed getting needed dental care, getting needed care quickly, how well doctors communicate, helpfulness and courteousness of doctor's office staff and customer service.

THE SURVEY SAMPLE

A random sample of families was selected using a modified version of the NCQA (National Committee for Quality Assurance) protocols for conducting the CAHPS® 2.0H survey. Families with children between the ages of 4 and 18 years of December 31, 2001 and who were continuously enrolled in their dental plan for at least 12 months were eligible to participate in the survey. Families with children under the age of 4 were not selected for the survey because of the likelihood that these children would not have seen a dentist. Of the families who were eligible for the survey, only those families who did not receive a previous HFP consumer survey for health plans were selected. The number of families selected for the survey from each dental plan participating in the HFP was 1,050. A total of 5,250 surveys were distributed. Table 1 shows the number of families who were selected for the survey for each participating dental plan.

Table 1 – Families Surveyed From Each Health Plan

Dental Plan	Number of families surveyed
Access Dental	1,050
Delta Dental	1,050
Denticare	1,050
Premier Access	1,050
Universal Care Dental	1,050
Total Program	**5,250**

Families selected for the survey received the survey in English, and Spanish, Korean, Vietnamese or Chinese if one of these languages was designated as the primary language on the families' HFP application. Table 2 outlines the distribution of the survey instruments mailed in each language for each health plan.

Table 2 – Distribution of Surveys in Each Language Group by Health Plan

Health Plan	Total	E	S	C	K	V
Access Dental	1,050	428	541	32	27	22
Delta Dental	1,050	472	456	78	33	11
Denticare	1,050	441	539	43	11	16
Premier Access	1,050	731	317	1	1	0
Universal Care Dental	1,050	351	611	59	13	16
Total	5,250	2,423	2,464	213	85	65

E= English S=Spanish C=Chinese K=Korean V=Vietnamese

THE SURVEY PROCESS

The survey was conducted using a protocol that was based on the protocol for the Medicaid CAHPS® 2.0H survey. Datastat conducted the survey over an eight week period using a single mode (mail-only) 5 step protocol between the months of February and April. This consisted of a pre-notification mailing, an initial survey mailing and a reminder postcard to all respondents, and a second survey mailing and second reminder postcard to non-respondents. The pre-notification and follow-up correspondences were developed based on recommended samples from the CAHPS®2.0H protocol.

Table 3 – Survey Timeline

Pre-notification letters mailed:	February 7, 2002
1st mailing of reminder packets:	February 14, 2002
2nd mailing of survey packets:	March 7, 2002
2nd mailing of reminder postcards:	March 14, 2002
Survey ends:	April 9, 2002

Because the D-CAHPS® survey was used for the first time and is still in development, the protocol for the telephone follow-up was not available.

SURVEY RESULTS

Response Rates

Of the 5,250 surveys mailed in 5 languages, 5,020 surveys were returned. Of the 5,020 surveys returned, only 2,536 surveys were considered "usable" based on the CAHPS® 2.0H survey protocol. The number of usable surveys was calculated by taking the number of surveys that were completed according to CAHPS® 2.0H protocol for conducting the survey. For this survey, 230 surveys were eliminated from the 5,250 surveys mailed, resulting in a net of 5,020 usable surveys.

Of the 5,020 usable surveys, a total of 2,536 were returned. The overall response rate for the survey was 50.0%. No dental plan participating in the survey had less than a 45% response rate with response rates ranging from a low of 45.9% to a high of 56.2%.

Below are the response rates for each participating dental plan.

Table 4 -- Response Rates for Each Health Plan

Dental Plan	Surveys mailed	Usable surveys	Usable responses	Response Rate
Access Dental	1,050	990	468	47%
Delta Dental	1,050	1,010	568	56%
Denticare	1,050	1,015	488	48%
Premier Access	1,050	1001	551	55%
Universal Care	1,050	1004	461	46%
Total	**5,250**	**5,020**	**2,536**	**50%**

Summary of Responses

The responses to the survey were summarized into four rating and five composite questions. Responses that indicate a positive experience were considered achievement scores. Charts displaying the survey results by dental plan are presented beginning on page 4 of this report.

Rating Questions Responses: For the four rating questions, a 10-point scale was used to assess overall experience with health plans, providers, specialists and health care. The achievement scores for these questions were determined by the percentage of families that responded to each question based on an 8, 9 or 10 rating. Individual plan scores for the 2002 survey are compared with the overall program score in 2002 and a *benchmark*. This benchmark is based on the highest score achieved by a participating dental plan with a minimum of 75 responses.

The results of the survey indicated that scores ranged from 63 to 73 percent of families rated their dental care, dental plan, personal dentist and specialist an 8, 9 or 10. The highest score achieved for the program

was in the rating of dental care specialists at 73 percent. The lowest dental plan rating scores were 63 percent for the rating of dental care.

Composite Score Results: For the survey, the composite question is grouped with other questions that relate to the same broad domain of performance. For example, the domain, "Getting Dental Care Quickly" includes questions about getting advice by phone, about how soon appointments were scheduled and about time spent waiting in the dentist's office. The achievement score for these questions is determined by the percentage of families who respond positively to each question. A response in considered positive if the answers are "not a problem" for the questions comprising the "Getting Needed Dental Care" and "Customer Service" composites, and "usually" and always" for the "Getting Care Quickly", "How Well Doctors Communicate" and "Courteous and Helpful Office Staff" composites. The survey questions that make up the composites scores are listed below.

"Getting Needed Dental Care"
- Able to get your child a dental office or clinic you are happy with
- Able to get a referral to a specialist for child
- Able to get the care for child believed necessary
- No problems with delays in child's dental care while awaiting approval

"Getting Dental Care Quickly"
- Usually or always got help of advice needed for child
- Child usually or always got an appointment to fill or treat a cavity as soon as wanted
- Child usually or always got an appointment for routine care as soon as wanted
- Child usually or always got needed care for mouth pain or dental problem as soon as wanted
- Child never or sometimes waited more than 15 minutes in dentist's office or clinic

"How Well Dentists Communicate"
- Dentists usually or always listened carefully
- Never or sometimes had a hard time speaking with or understanding the dentist because you spoke different
- Dentists usually or always explained things in an understandable way
- Usually or always got an interpreter when needed
- Child usually or always got an interpreter when needed.
- Child never or sometimes had a hard time speaking with or understanding dentist because he or she spoke different languages
- Dentists usually or always explained things to child in an understandable way
- Dentists usually or always spent enough time with child

"Courteous and Helpful Office Staff"
- Usually or always treated with courtesy and respect by office staff
- Office staff usually or always helpful

"Customer Service"
- Able to find or understand information in written materials
- Able to get help needed when you called child's dental plan's customer service

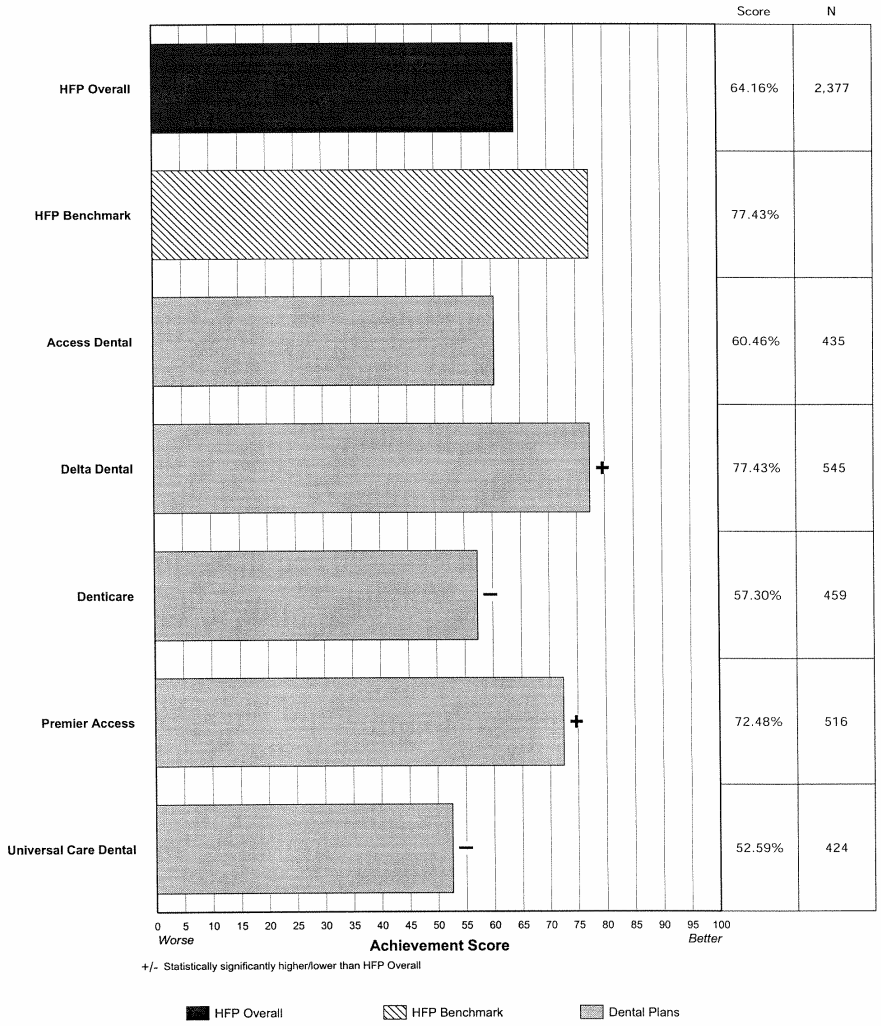
The results of the survey indicated that the scores ranged from 53 to 81 percent of families rated their access for getting needed dental care, getting dental care quickly, how well dentists communicate, courteous and helpful office staff and customer service an 8, 9 or 10. The highest score achieved for the program was in the rating of how well dentists communicate at 81 percent. The lowest dental plan rating scores were 53 percent for the rating of customer service.

SURVEY RESULTS FOR PARTICIPATING DENTAL PLANS

The results for each participating dental plan is presented in the following charts. Plans that have achievement scores significantly higher or lower than the program score are indicated by a "+" or "-" next to their scores.

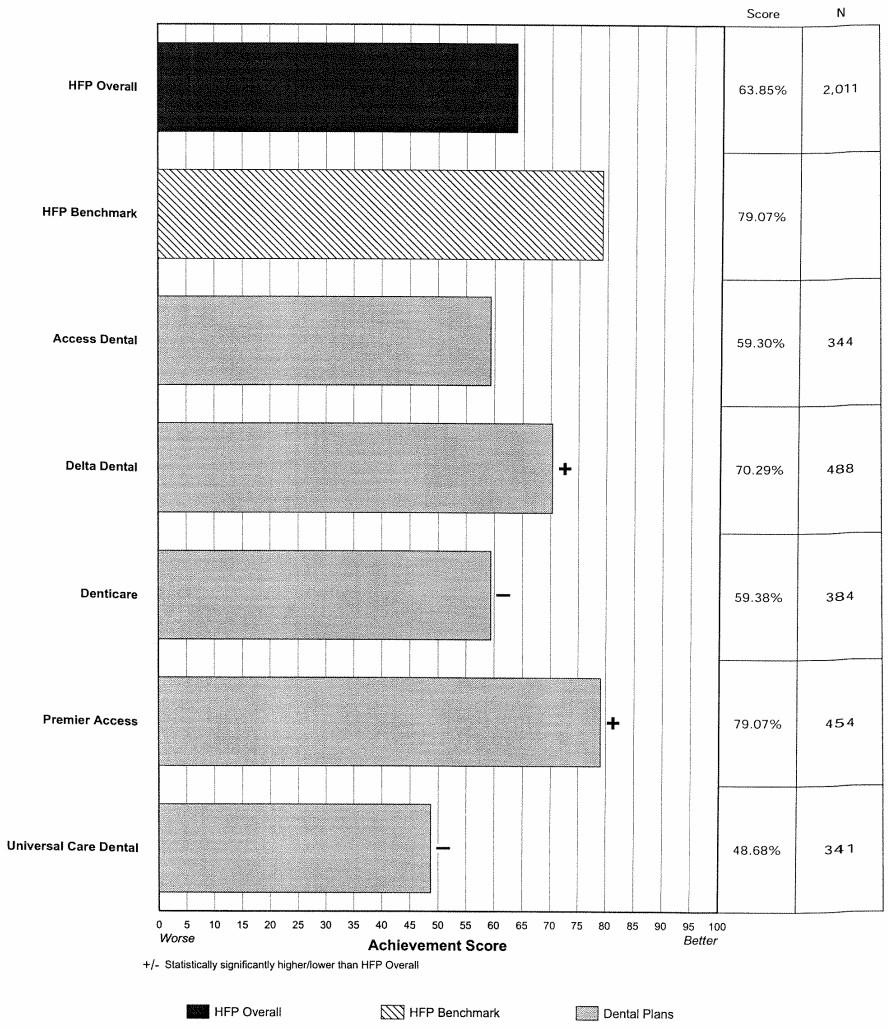
Overall Ratings

Q52. Overall rating of dental plan



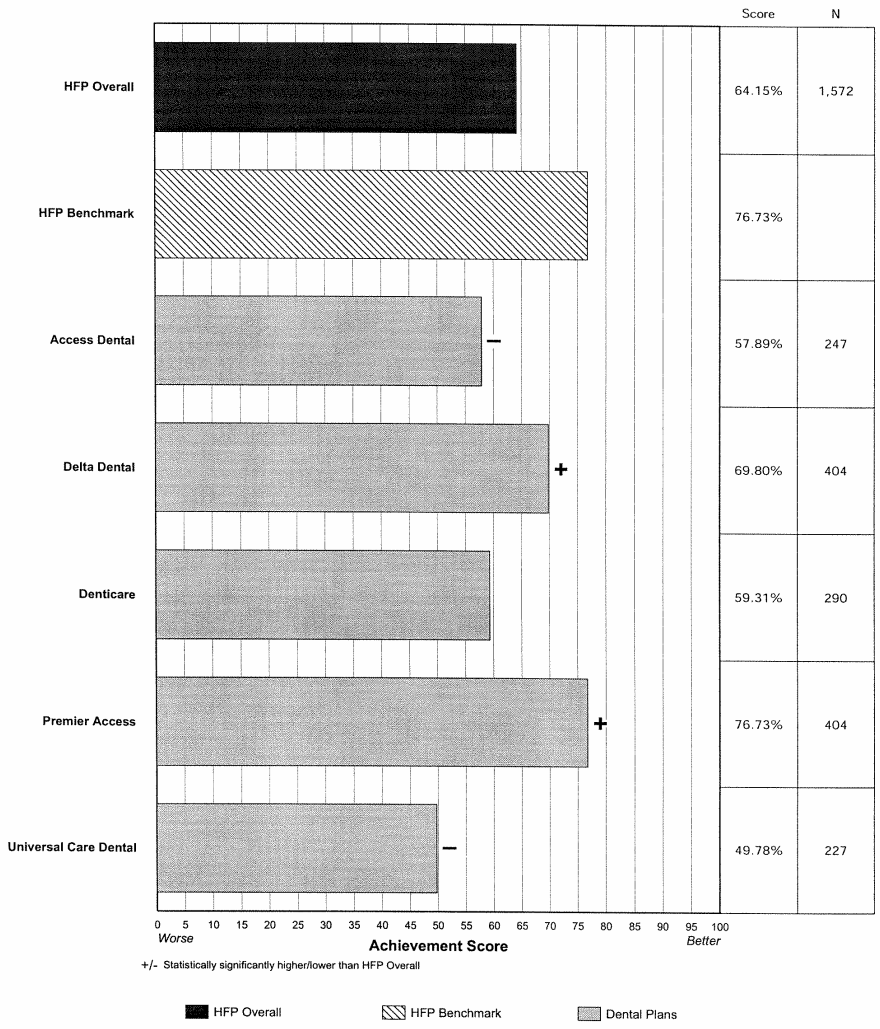
Overall Ratings

Q40. Overall rating of dental care



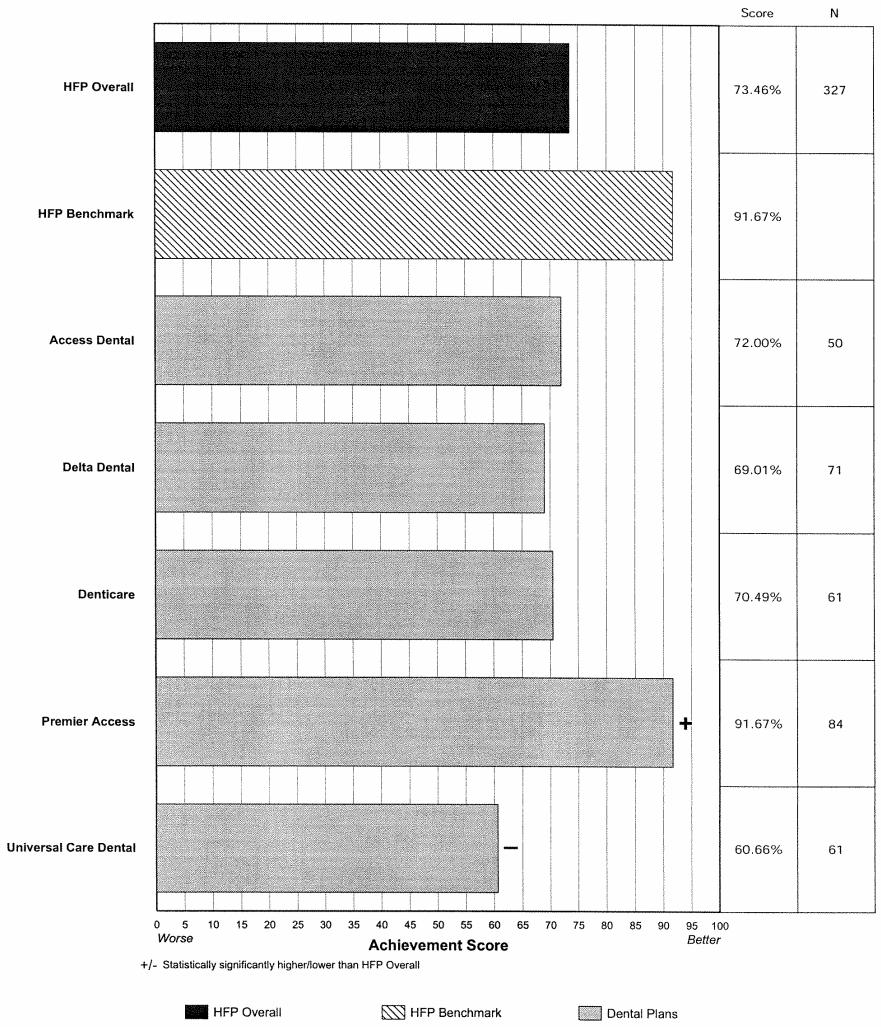
Overall Ratings

Q9. Overall rating of personal dentist



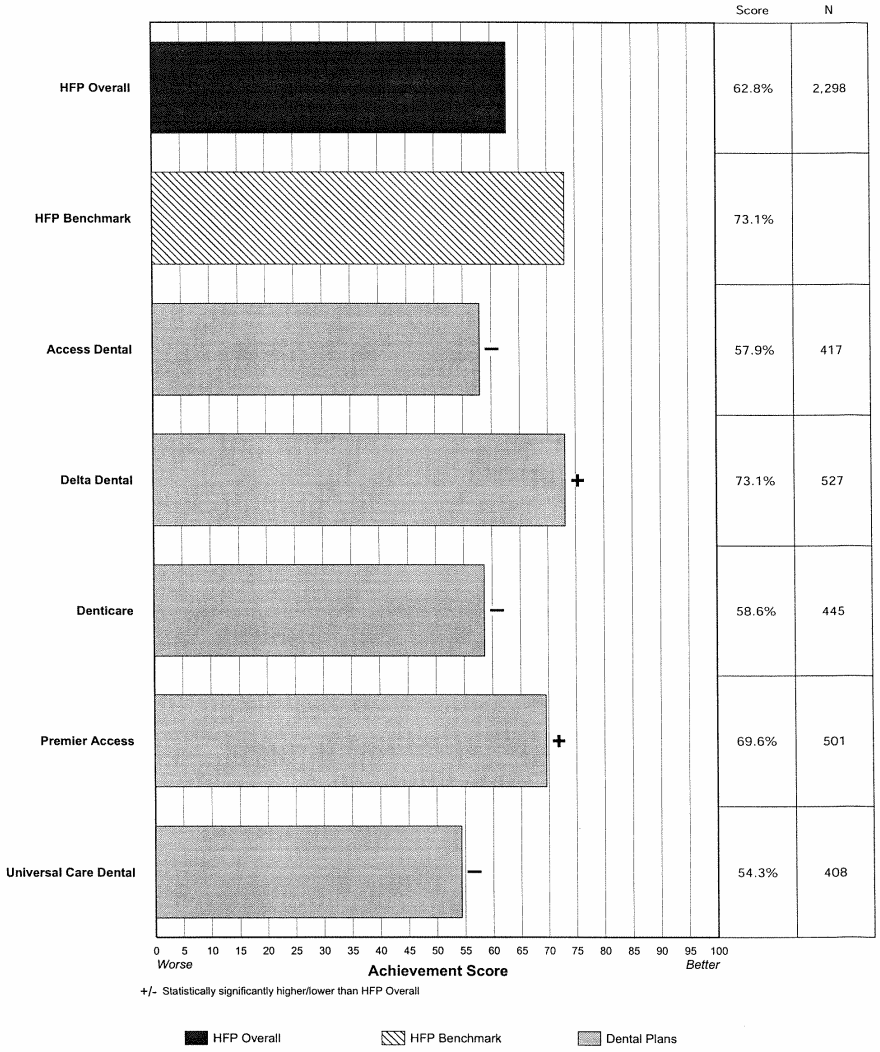
Overall Ratings

Q14. Overall rating of dental specialist



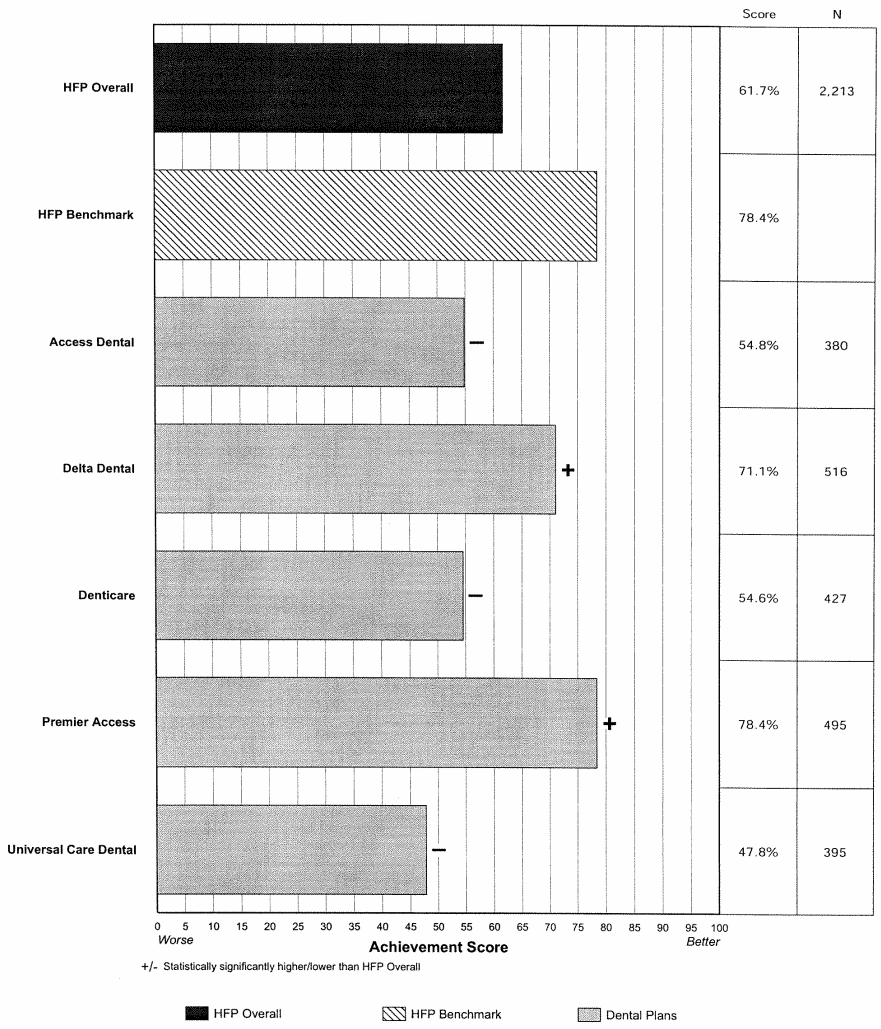
Getting Needed Dental Care

Composite Score



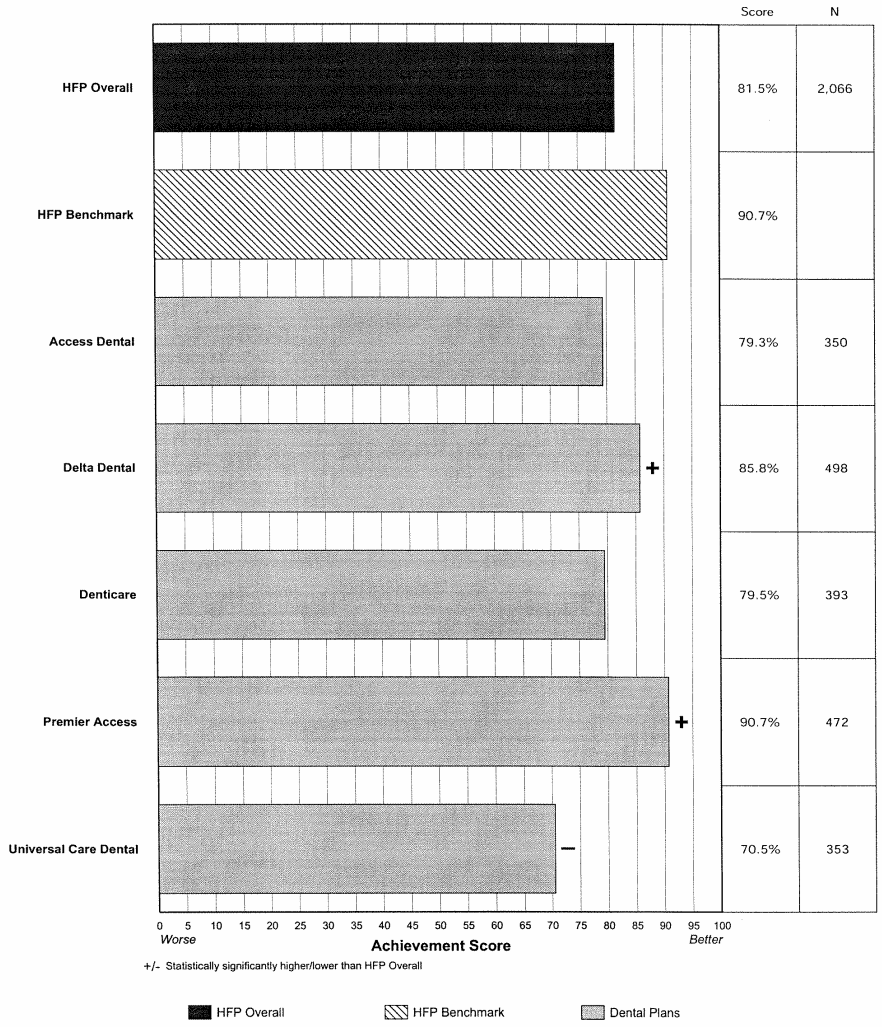
Getting Dental Care Quickly

Composite Score



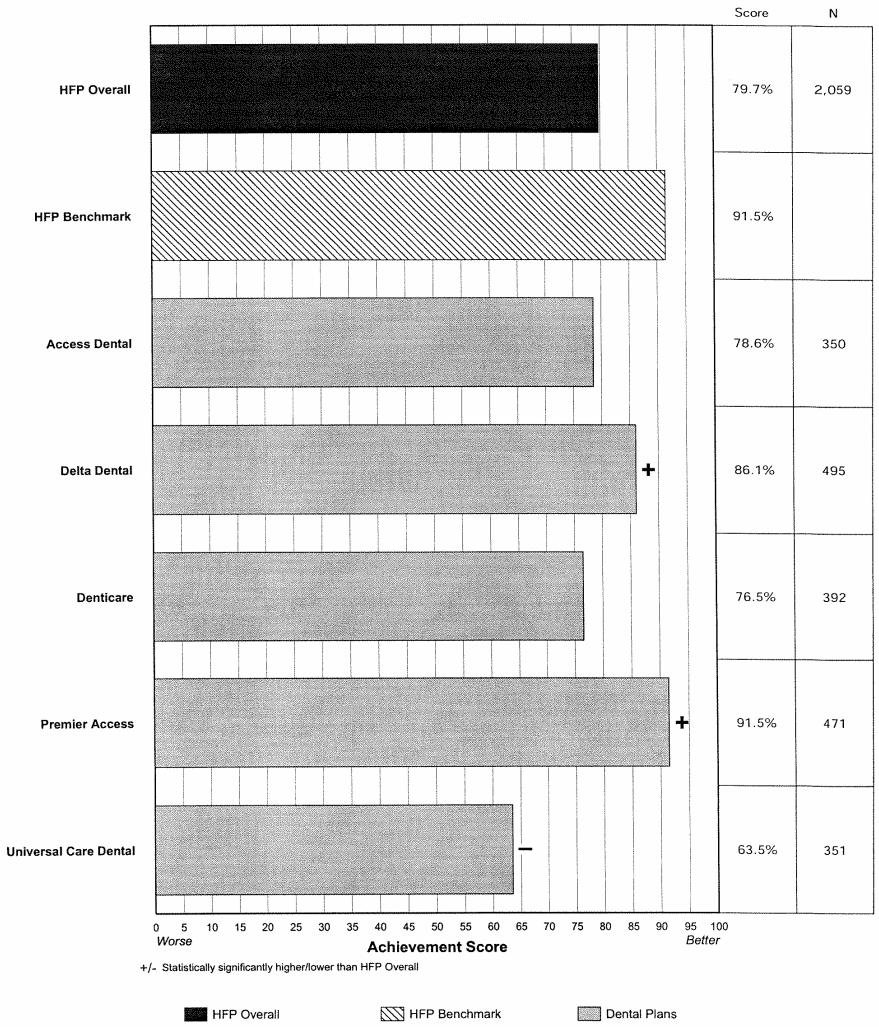
How Well Dentists Communicate

Composite Score



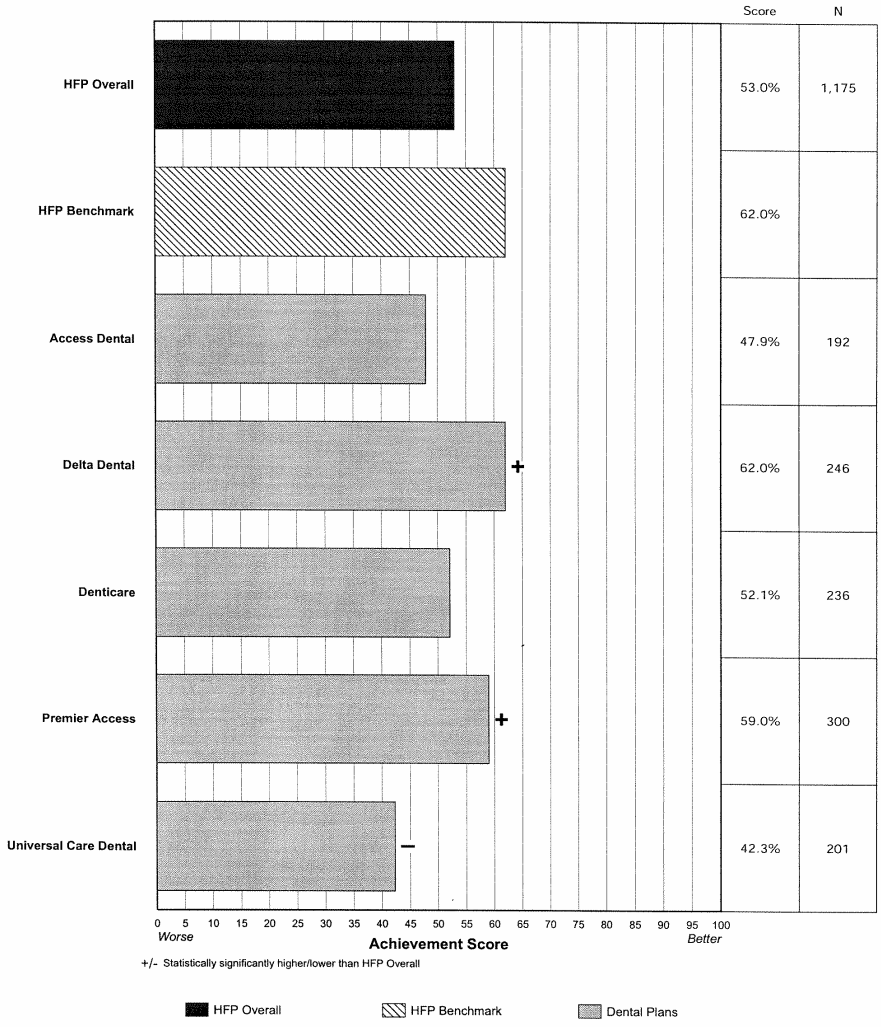
Courteous and Helpful Office Staff

Composite Score



Customer Service

Composite Score



ATTACHMENT 9

Healthy Families Program Cultural and Linguistic Group Needs Assessment Report

Healthy Families Program
Cultural and Linguistic Group Needs Assessment Report

September 2002

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Healthy Families Program
Cultural and Linguistic Group Needs Assessment Report

The demographic profile of the Healthy Families Program (HFP) reflects the rich diversity that exists in California. Recent estimates from the 2001 California Health Interview Survey indicate that the race/ethnic makeup of children eligible for the HFP are as follows: 66 percent Latino, 21 percent White, 7 percent Asian/Pacific Islander, 2 percent African American, 1 percent Native American/Alaska Native and 3 percent multiple races. According to current enrollment data, the ethnic distribution in the HFP is similar to these estimates. Sixty-seven percent of current enrollees are Latino, 16 percent are White, 13 percent are Asian/Pacific Islander, 3 percent are African American and less than 1 percent are American Indian/Alaska Native.

In addition to the ethnic diversity, there are many language groups represented among HFP applicants and subscribers. Of the primary languages recorded on the program applications, 50 percent of applicants indicate English as their primary language, 41 percent indicate Spanish, 3 percent indicate Chinese and approximately 3 percent indicate Vietnamese and Korean. Other languages constitute less than 3 percent of the total applicants.

A key factor in successfully providing access to comprehensive, quality health care coverage through the HFP is the ability of participating plans to address the needs of this diverse population. The ability of providers to communicate with subscribers and their parents is only one part of the equation. Health care providers and participating plans must be able to address the incidence of disease among their HFP patients and the efficacy of medical treatments for this population. Participating providers and plans must also recognize that subscribers from various ethnic groups may have distinct patterns of health beliefs, values, and behaviors, all of which can significantly affect the level of compliance with prescribed treatment.

The HFP health, dental and vision plan contracts include specific requirements to address the cultural, linguistic and educational needs of the enrolled population. In the 1998/2000 contracts, plans were specifically required to comply with Title VI of the 1964 Civil Rights Act. This federal requirement prohibits recipients of federal funds from providing Limited English proficient persons with services that that are limited in scope or lower in quality than those provided to English proficient individuals. An individual's

participation in a federally funded program or activity may not be limited on the basis of Limited English proficiency.

In the 2000/2003 HFP plan contracts, MRMIB expanded its cultural and linguistic services requirements to include specific activities for providing linguistically and culturally appropriate services. These requirements were largely based on policies that the Department of Health Services implemented for the Medi-Cal Managed Care program. One key activity required by both Medi-Cal Managed Care, and subsequently Healthy Families, is for plans to conduct a Cultural and Linguistic Group Needs Assessment (GNA).

The HFP Group Needs Assessment requirement, which is based on the requirement used by the Department of Health Services for the Medi-Cal Managed Care Program, called for plans to examine certain characteristics of their HFP members, and to implement activities that would result in improved culturally and linguistically appropriate services.

Each HFP participating plan was required to conduct a GNA to identify the health risks, beliefs, and practices of their HFP subscribers. Each HFP plan was also required to develop work plans in response to identified health education, cultural and linguistic needs, including a timeline for implementing the work plan. The GNA and work plan were due to MRMIB on June 30, 2001.

In conducting the GNA, participating plans were to identify the following for their HFP subscribers:

- health-related behaviors and practices
- risk for disease, health problems, and conditions
- knowledge, attitudes, beliefs, and practices related to access and use of preventive care
- knowledge, attitudes, beliefs, and practices related to health risk
- perceived health, health care and health education needs and expectations
- cultural beliefs and practices related to alternative medicine
- perceived language needs and preferred methods of learning
- language needs and literacy level
- community resources and capability to provide health education and cultural and linguistic services

As was the case with Medi-Cal Managed Care, participating HFP plans were encouraged to use a variety of resources to gather information about their HFP subscribers. They were also required to provide opportunities for representatives of HFP subscribers to provide input on the GNA. In addition to identifying the health risks, beliefs and practices of subscribers, plans were required to develop health education programs in response to identified needs, with advice from representatives of subscribers.

Methodology for Conducting the Group Needs Assessment

Health plans that had conducted a GNA for Medi-Cal Managed Care were allowed to conduct the HFP GNA using the same methods used for the Medi-Cal Managed Care GNA. Some of these methods included using data from national, state and county agencies, obtaining information on health education and cultural and linguistic needs from community advisory committees, and surveys of plan providers. All participating plans were instructed to refer to the Medi-Cal Managed Care's GNA requirements for guidance. (The Medi-Cal Managed Care's GNA requirements were outlined in a policy letter, PL 99-02, which was sent to managed care plans participating in Medi-Cal Managed Care.) Plans that did not participate in Medi-Cal Managed Care were encouraged to collaborate with any HFP participating plan that serves Medi-Cal Managed Care. MRMIB staff shared sample outlines from a few Medi-Cal Managed Care GNAs with all plans to assist them in initiating their GNAs.

Participating HFP plans used a multitude of data sources for gathering information about the health related cultural and linguistic characteristics of ethnic and language groups represented in their HFP membership. The variety of data sources used for the HFP GNA was also seen in the Medi-Cal Managed Care Program.

Among the multitude of methods available to conduct the GNA, some methods were used by most plans and other methods were used by only a few plans. It appeared that most plans used two types of data sources; quantitative data from published sources or from claims and encounter data housed in the plan's internal data systems, and qualitative data from surveys, interviews or focus groups. With respect to quantitative data, the sources plans used included federal, state or county health data, HFP enrollment data, plan claims and encounter data, prevalence and incidence reports from published studies, and local needs assessment reports. Qualitative data was usually obtained from questionnaires or discussion guides developed by individual plans.

Quantitative Data

Plans obtained quantitative data on racial and ethnic health disparities, disease prevalence, mortality and morbidity rates and county demographic data (age and ethnic composition, languages spoken and income level) from federal, state and county sources (e.g., U.S. Department of Health and Human Services, the Centers for Disease Control and Prevention, California Department of Health Services, county public health departments, etc.). Plans used their claims and utilization data to gather information on the most common diagnoses and medications most frequently dispensed for their HFP subscribers. Plans also examined patterns of hospital admission by ethnicity and emergency room visits for HFP subscribers.

Many plans collected information from published reports on causes of health disparities among ethnic groups, access to care, cultural and linguistic barriers and the impact of health literacy. Sources of this information included studies prepared by national and state agencies and private philanthropic foundations. Examples of these reports include:

- The California Endowment and California Healthcare Foundation's *The Health Status of Latinos in California* (1992).
- The California Center for Health Improvement, the National Center for Education Statistics and the American Medical Association Foundation report on adult literacy competency and the impact of low literacy on health care issues (2000).
- The Dental Health Foundation's *Oral Health Needs Assessment of Children* (1993-1994).
- U.S. Department of Health and Human Services, National Standards on Culturally and Linguistically Appropriate Services in Health Care (December 2000).
- The Henry J. Kaiser Foundation report on the evidence of racial and ethnical health disparity in insurance coverage, access to primary care and treatment for specific medical conditions (1999).

Qualitative Data

In addition to quantitative data, a majority of plans used surveys, interviews and/or focus groups to obtain information directly from members, network providers and community based organizations (CBOs). The surveys assessed a variety of factors, including health education services utilized by members and providers, the top health education needs of subscribers, and services provided by the providers and community organizations. Other topics covered by the surveys included perceived barriers that impact access to care (such as mistrust of the health care system), preferred learning methods, top preventive and environmental health risks/concerns, the members' use of alternative medicines, language capability of providers and cultural sensitivity of the office staff.

Focus groups and interviews were conducted to supplement the external or survey data they obtained. Some plans gathered information from standing consumer committees, community advisory boards, or public policy committees comprised of members/parents, providers, and community advocates. One health

plan conducted a focus group comprised of adolescents, ages 14 to 18, on adolescent health care habits, health related topics they are interested in and health education materials they would like to receive.

In addition to the surveys, focus groups and interviews designed to address specific issues related to the GNA, plans also used results of the HFP Consumer Survey of Health Plans and their HFP Health Plan Quality Report to evaluate members' ability to access health care as well as their satisfaction with the services received.

Plan Activities to Address Identified Needs

Each participating plan identified several activities that it would implement to address the needs identified in the GNA. Most of the activities included education programs for subscribers, plan staff or network providers. Other types of activities target an aspect of a plan's infrastructure (e.g., modifying current information systems to improve tracking of cultural and linguistic needs of members).

Findings Summary

The findings that plans made in their GNA report can be generalized into five major areas. These areas and the types of activities plans proposed to address them are outlined below.

Finding 1 ►

Similarities exist among health and dental risks reported in national, state and local studies, health risks identified in claims and encounter data, and health, dental and vision education topics desired by HFP subscribers.

Most plans reviewed published reports to determine the health risks among children in general and children from various ethnic backgrounds. The data reported by plans showed that:

- Type II diabetes mellitus during childhood is the third most prevalent disease affecting all Native American tribes Latinos are 2.2 times more likely and African Americans are 2 times more likely to develop diabetes than Caucasians
- More African American children and adolescents are overweight when compared to that of Caucasian children and adolescents. It is suspected that this may be due to higher caloric intake and less physical activity
- African Americans have a 6 times higher rate of asthma hospitalizations than Caucasians
- California ranked 40th in the nation in the percentage of children who are adequately immunized

- Only 43 percent of Latino children in California have completed their immunization series by age 2
- Half of all children will have at least one episode of an ear infection by one year of age, and 35 percent of these will have a repeat episode
- Children in low-income families, who are usually members of racial and ethnic minority groups, are particularly vulnerable to dental disease
- Oral disease is commonly cited as the most widespread health problem nationwide particularly among children

In addition to data from published reports, plans reported data from an analysis of their administrative files. Health plans indicated that asthma, allergies, upper respiratory infections, and ear infections and/or ear pain, were the most common diagnoses among their HFP subscribers. A few health plans reported that asthma is one of the most frequent reasons for emergency room visits among HFP subscribers. Other plans reported that their pharmacy data shows that upper respiratory infections, including ear pain and/or ear infection, constitutes the number one disease category for total cost of prescriptions among their HFP subscribers.

Member surveys conducted by a few plans showed that families are interested in health education topics that address dental health, eye care for their families, and the prevalence of asthma, diabetes, etc. Specific topics of interest include:

- Diabetes/weight management/nutrition
- Asthma
- Safety and injury prevention
- Exercise and sports for children
- Oral health
- Preventive eye care and symptoms of eye problems

Provider surveys conducted by a few plans found that education on well child care, antibiotics use, smoking prevention/cessation and substance abuse were also important topics for HFP subscribers.

Action Steps ►

In response to these findings, plans identified several activities that will target educational efforts in these areas. Examples of these include:

<u>Diabetes/weight control</u>

- Implementing an Obesity/Type II Diabetes education and prevention program
- Developing a childhood obesity educational campaign

- Creating a committee of professionals working with children and adolescents to create a brochure listing all resources for nutrition, weight management and exercise programs that are available in the community
- Distributing a provider update bulletin to all plan HFP providers on how to access health education materials on nutrition, injury prevention, and other important health issues

Asthma education

- Asthma education program
- Searching for effective asthma intervention and management strategies

Safety and injury prevention

- Providing a bicycle safety education course for members with efforts made to either purchase or have donated helmets to distribute during events
- Implementing a car seat distribution program
- Promoting the importance of injury prevention among HFP members through newsletters

Preventive care

- Providing health education information and resources to HFP providers about immunizations and to improve immunization rates of children 2 years and younger
- Promoting the importance of childhood immunization through member newsletters
- Implementing a quality improvement program to increase immunizations and well-child visits screening rates among plan subscribers
- Raising awareness of the importance of preventive health visits among adolescents
- Promoting incentives for well-care visits
- Developing a brochure on the importance of well-child and well-adolescent care visits among HFP through member mailings
- Increasing the number of initial exams and preventive

Infection control

- Implementing an ear infection education campaign
- Implementing an antibiotic education campaign

Oral Health

- Developing appropriate oral hygiene brochures that explain the danger of dental caries and the importance of dental visits
- Disseminating dental health information to members through member newsletters, on plan websites, and including information in the “on-hold” messages in the phone system

Eye Care

- Creating health education materials that explain the importance of annual eye examinations and provide general information about common eye disorders for children

Finding 2 ►

Subscribers may not fully understand how to access plan services and their rights under the HFP.

Survey results from members, providers and CBOs indicated that members:

- Lacked knowledge of the managed care system and awareness of what benefits are available, and knowledge on how to use the plan
- Believed that the health care system is indifferent and a determining factor in health care delivery
- Were skeptical about using their health plan because of historic lack of access to care and poor outcomes
- Feared deportation or denial of citizenship might create a barrier to utilization of health care services

Action Steps ►

Examples of plan activities to increase subscriber's knowledge of the managed care system and member rights include:

- Providing members with culturally and linguistically appropriate education to promote their understanding of managed care plan services, health care benefits, and members' rights and responsibilities
- Exploring different ways to educate members on how to navigate and use the health care system
- Providing more information to help members understand their benefits
- Providing guidelines to members/subscribers through plan newsletter on the appropriate use of emergency room
- Collaborating with the Member Service Department to improve the benefit information given to members
- Hosting a HFP forum to give consumers, advocates and providers the opportunity to discuss their ideas, concerns and support for the HFP with their legislators and government officers, and to clarify misunderstandings and issues of concerns including the issue of public charge
- Developing resource guides that address the fear of government authority, especially among non-English speaking potential HFP members

Finding 3 ►

Differences in languages spoken between providers and HFP subscribers must be addressed

Plans must be able to communicate with subscribers/members in their preferred language. Based on results from surveys conducted with subscribers, providers and CBOs, several plans reported that:

- Members prefer to read educational materials in their primary language
- Literature and videos on health education should be made available in members' preferred languages
- Forms should be made easier to read and to complete
- Provider training is needed on health literacy and how to work with low-literacy patients

Several plans also indicated that most providers:

- Are aware that linguistic differences can present a barrier to health care for patients
- Believe that a very important factor to patients when seeking care is finding a provider who speaks their language and who is culturally sensitive
- Are interested in training for bilingual staff on medical interpretation

Action Steps ►

A large number of plans have identified activities that they will implement to improve their infrastructure so that it is responsive to members' linguistic health services need. Examples of these activities are:

- Developing a language certification services program for bilingual staff
- Maintaining an information system capable of identifying and profiling cultural and linguistic specific patient data
- Developing and maintaining linguistic standards and training, including supporting providers in maintaining the plan's linguistic standards
- Assessing the linguistic appropriateness of systems such as appeals and grievances, appointment and scheduling
- Developing a library for linguistic related reports
- Better informing providers of the availability of several options to assist providers with their limited-English speaking members
- Providing training to providers and office staff on how to work with medical interpreters
- Ensuring that plan providers have access to appropriate health education materials and linguistic resources

- Ensuring that the contractually required translations are made by maintaining and tracking data on language of HFP members
- Developing a communication and information program that is effective and sensitive to the multilingual subscribers of the plan
- Developing ongoing strategies for member's education on accessing linguistic services through the Evidence of Coverage (EOC), and member newsletters
- Assessing the cost and logistical requirements to produce HFP information materials in languages other than the acknowledged threshold languages to assist members on how to use plan services and make the plan a more desirable choice among other HFP participating plans in the community
- Continuing to monitor the linguistic capabilities of the plan's provider network to assure access to linguistically appropriate services throughout the plan's contracted service areas
- Evaluating the best method for providing health education materials to network providers in each of the plan's threshold languages, and ensuring that every network provider office displays translated, written educational materials in a visible location

Finding 4 ►

Providers need training to increase their cultural competency skills.

The HFP contract encourages participating plans to develop internal systems that meet the cultural needs of the plans' HFP subscribers. Examples of these internal systems are assessing the cultural competence of plan providers on a regular basis, and evaluating the need for special initiatives related to cultural competency.

Reports from several plans identified the following needs:

- Training of providers on cultural competency and awareness
- Training of front office staff on treating clients with more respect
- Educating members to communicate their use of traditional healing
- Expansion of quality improvement programs (QIP) to include practices to providers so providers can better serve their

needs a routine analysis of the quality of health care services provided to members and whether there are disparities in health outcomes

Several plans also indicated that most providers:

- Are aware that cultural differences can present a barrier to health care for patients
- Believe that a very important factor to patients when seeking care is finding a provider who is culturally sensitive
- Are interested in cultural competency education and cultural sensitivity for office staff
- Recognize that knowing about patients' cultural beliefs and practices related to health care, lifestyle and religious beliefs would help them to better serve patients

Results from plan surveys conducted of subscribers, providers and CBOs revealed that:

- Members want a culturally sensitive health care environment that is understanding and respectful of differences
- Members want providers who share their culture

Action Steps ►

A large number of plans have identified activities that they will implement to improve their infrastructure so that it is responsive to their member's cultural and linguistic health services need. Examples of these activities are:

- Providing initial and continuing training on cultural competency to staff
- Developing recruitment and retention initiatives to establish organization-wide staffing that is reflective and responsive to the needs of the community
- Maintaining an information system capable of identifying and profiling cultural specific patient data
- Incorporating cultural services in plan's mission statement
- Developing and maintaining cultural standards and training, including diversity training and supporting providers in maintaining plan's cultural standards
- Implementing a program to increase awareness and cultural competency and sensitivity in health care delivery among the staff, administrators and providers in the network
- Assessing the cultural and appropriateness of systems such as appeals, grievances, and appointment and scheduling
- Developing a library for cultural related reports

- Sharing with plan providers what the plan has learned about the cultural beliefs and practices of the plan's population and continue to educate providers on different ethnic group's view of health and healing and providing helpful strategies for working with these differences
- Increasing members' and providers' access to culturally appropriate health education materials

Finding 5►

Community-Based Organizations (CBOs) can assist plans in providing culturally and linguistically appropriate services

Plans report that information gathered from the members and providers, as well as teen focus groups indicate that:

- Providers, CBOs and family members play important roles in promoting and advocating health issues among certain ethnic groups
- There is a greater need for advertising and promotion of community resources
- Relationships between the plans and CBOs should be strengthened
- Plans can benefit from information received from member focus groups such as those specifically designed to address issues relevant to their teen members

Action Steps ►

A large number of the plans' GNAs contain action steps related to actively involving plan members, plan providers, and the community in the development and provision of culturally and linguistically appropriate health services. Some of the collaborative initiatives to be undertaken include:

- Maintaining on-going functioning committees (e.g., Advisory and/or Public Policy) with member and community representatives. One plan will be diversifying its Advisory Committee to include more CBOs and threshold language populations. Another plan is exploring the feasibility of establishing a Youth Advisory Committee to better understand issues that youth face and to provide them with an opportunity to provide input directly to the plan. Another activity is to continue the provision of resources to when to make referrals to community services
- Conducting member surveys and focus groups to solicit consumer information and to identify the needs and opinions of a broad representation of ethnic groups

- Developing a link between the county public health department and the plan to coordinate education and outreach resources
- Continuing participation in the county health services cultural and linguistic committees which advise plans on cultural and linguistic issues, training, access and recruitment of qualified bilingual, bicultural staff
- Establishing effective partnering strategies with CBOs to investigate identified cultural barriers to patient care and sharing resources which are culturally competent for member health education and other services to members
- Establishing CBO contracts for outreach to communities such as the African American and Cambodian communities
- Providing health education in the communities where members reside through community outreach programs and collaborating and sharing resources with CBOs

Conclusion

The GNA requirement resulted in plans focusing their efforts on developing culturally and linguistically appropriate services for their subscribers in key areas. Many plans reported that the GNA helped them prioritize their health education services and resulted in the development of plan-wide activities to address structural issues that are important to meet the cultural and linguistic needs of their subscribers. The GNAs also uncovered weaknesses in current practices for providing linguistically appropriate services (e.g., free interpreter services). Finally, the GNAs have resulted in some plans initiating collaborative relationships with CBOs and advocates to provide culturally and linguistically appropriate services.

The variety of activities that plans will implement to address the needs identified in the GNA provide an opportunity to observe which activities are most successful in providing culturally and linguistically appropriate care. Since a standard set of activities for addressing cultural and linguistic needs for various ethnic populations does not exist, participating plans will be experimenting with various ideas and methods. Through this experimentation, participating plans and MRMIB will discover best practices for providing culturally and linguistically appropriate services that can be shared with all plans and result in program-wide enhancements in the provision of culturally and linguistically appropriate services. Next year, MRMIB will be able to assess the progress plans are making in implementing these activities through the annual Cultural and Linguistic Services Report. This report provides MRMIB with

descriptions of how plans will provide culturally and linguistically appropriate services for the upcoming benefit year.

Future Considerations

No broadly accepted standard exists in California or elsewhere for conducting GNAs or for developing activities to meet the needs identified. As a result, HFP participating plans have submitted different results and work plans which allow MRMIB to observe the success of the various activities implemented by participating plans

The GNA requirement for the Medi-Cal Managed Care Program and the HFP was a new concept for plans participating in these programs. Although Medi-Cal and/or HFP participating plans were required to comply with Title VI of the Civil Rights Act of 1964, the GNA requirements pushed each plan to examine the demographic diversity and unique health-related needs present within the plan's membership. The Department of Health Services was the State's and nation's pioneer in developing specific standards for plans to undertake to respond to the cultural and linguistic needs of their subscribers. The HFP requirements are modeled on this groundbreaking work of the Department of Health Services, which occurred three years ago. Given that conducting GNAs is a new requirement for participating plans, little information is available about the effectiveness of GNAs in expanding access to culturally and linguistically appropriate services provided by participating plans.

Assembly member Wilma Chan introduced AB 2739 that would codify the cultural and linguistic requirements that currently exists in the HFP contracts. Included in the bill is a requirement that plans conduct a GNA every three years. At the request of MRMIB staff, the sponsors of the bill indicated they were willing to extend the periodicity of the GNA requirement in the bill, but were unable to submit changes to Assembly member Chan's office before the deadline. The bill's sponsors have committed to pursuing clean-up legislation that would require GNAs to be conducted every five years or when there is a material change in the demographic mix of a plan's HFP enrollment. The sponsors have also agreed to give MRMIB more flexibility in determining the elements of the GNA based on new developments in the field and advice from experts in the provision of cultural and linguistically appropriate services, health education, and experts in conducting needs assessments. On August 30, 2002, the bill was passed by the Senate and was sent to the Governor for signature.

For future GNAs to be useful, it will be necessary for MRMIB to address a few lessons that were learned from this first round of GNAs. First, the wide range of GNA results and work plans will provide an opportunity to identify best practices. However, once best practices are identified, MRMIB will need to consider how it

might reflect these best practices in the contract requirements for the GNA. Examples of how this might be addressed may be for plans to further evaluate the effectiveness of a particular best practice, or provide a timeline for implementing a particular best practice.

Second, a broader collaboration among health plans requires leadership by MRMIB staff. Although plans were encouraged to work together to conduct their GNAs, only a few plans collaborated with one another and the collaboration was only focused on one aspect of the GNA. Since plans reported that conducting a GNA requires significant staff resources, the leverage of resources across all plans to conduct a more comprehensive GNA did not occur. For future GNA requirements, MRMIB staff will form a collaborative with participating HFP plans and the Medi-Cal Managed Care Program to identify ways for plans to conduct their GNAs more efficiently.

As a final note, MRMIB staff will hold discussions with individuals who have expertise in the area of health education, needs assessment and cultural and linguistic services to ensure that the GNA requirements reflect the latest thinking in the field. Since the federal Office of Minority Health has issued specific guidelines for providing culturally and linguistically appropriate services, it is expected that health plans and public programs around the country will be developing methods for implementing these guidelines. To date there have been several national and statewide conferences on the topic. Through these formal venues, the GNA requirements will be kept current in methodology and relevant to the populations being served.